INSTRUCTION / INFORMATION SHEET

PRESCRIBING PSYCHOLOGIST - (PROFESSION CODE 074)

A CURRENT ILLINOIS CLINICAL PSYCHOLOGIST LICENSE IS REQUIRED FOR PRESCRIBING PSYCHOLOGIST LICENSURE.

APPLICATION FOR PRESCRIBING PSYCHOLOGIST LICENSURE

- Part I – Box 5, page 1 – Indicate your current Illinois clinical psychologist license number.
- Part II – VIII – Complete all applicable information requested on pages 1 and 2.

APPLICATION FEE

The application fee is $150 for a license by acceptance of examination. The application fee is $100 for a license by endorsement. The fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation. **THIS FEE IS NON-REFUNDABLE.**

PRESCRIBING PSYCHOLOGIST LICENSURE REQUIREMENTS

Specific instructions are located on page 2. You must demonstrate that you meet the education, clinical training and examination requirements for prescribing psychologist licensure. Additional information regarding specific licensure requirements may be found in the Prescribing Psychologist sections 1400.200 – 1400.260 of the Administrative Rules at idfpr.illinois.gov.

Completion of a full-time practicum including at least 14 months supervised clinical training of at least 36 credit hours, and a research project are required for licensure. During the clinical rotation program, completion of rotations in emergency medicine, family medicine, geriatrics, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, surgery and one elective of the program participant's choice is required. Please see Section 1400.220 of the Administrative Rules for detailed information.

SUBMISSION OF APPLICATION

The two-page application, supporting documents and fee payment should be forwarded as a complete packet to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7007
Springfield, IL 62791

APPLICATION EXPIRATION

The application is valid for three (3) years from the date of receipt. Prescribing psychologist licenses expire on September 30 of each even-numbered year.

MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCE LICENSE

If you have been delegated prescriptive authority to prescribe Schedule III, IV or V controlled substances, you will be required to apply for a mid-level practitioner controlled substances license in accordance with the Illinois Controlled Substances Act. Written collaborative agreements do not need to be forwarded to the Department with your application.

Your controlled substance license will not be issued until your prescribing psychologist license is issued. A collaborating physician may delegate prescriptive authority for non-narcotic Schedule III, IV and V drugs. Prescriptive authority for any Schedule II substances, benzodiazepine Schedule III controlled substances and any narcotic drug as defined by Section 102 of the Illinois Controlled Substances Act may not be included in the written delegation of prescriptive authority. You must submit the Controlled Substance license application, fee and Delegation of Prescriptive Authority form.

ASSISTANCE IN COMPLETING THE APPLICATION

If you need assistance in completing the application, you may call 1-800-560-6420 or (TTY) 1-866-325-4949.

The Illinois Clinical Psychologist Practice Act and Rule and additional application forms can be downloaded from the IDFPR website at: idfpr.illinois.gov

PRESCRIBING PSYCHOLOGIST LICENSE

Submit the following documents and/or forms with the two-page application and fee:

1. Supporting document PHQ **must** be completed and submitted with each application. Your application will not be processed without completion of this form.

2. Official transcripts with school seal affixed from a regionally accredited institution recognized by the Council for Higher Education. The transcripts must document completion of the following required courses. The courses may be completed at the undergraduate, master's or doctoral level.

The transcripts must substantiate proof of successful completion of at least 3 semester credit hours or quarter-hours equivalent, including but not limited to the following biomedical subject areas:

- Medical Terminology (class or proficiency);
- Chemistry or Biochemistry with lab (2 semesters);
- Human Physiology (one semester);
- Human Anatomy (one semester);
- Anatomy and Physiology (one semester);
- Microbiology with lab (one semester);
- General biology for science majors or Cell and Molecular Biology (one semester).

The transcripts must also substantiate proof of successful completion of a minimum of 60 semester credit hours or quarter hours equivalent to 60 semester hours of didactic coursework that includes, but is not limited to, the following 10 subject areas. A minimum of 3 semester hours or equivalent quarter hours must be completed in each of the following 10 subject areas:

- Pharmacology;
- Clinical Psychopharmacology;
- Clinical Anatomy and Integrated Science;
- Patient Evaluation;
- Advanced Physical Assessment;
- Research Methods;
- Advanced Pathophysiology;
- Diagnostic Methods;
- Problem Based Learning;
- Clinical and Procedural Skills.

3. Academic Criteria Form (AC-PP FORM) identifying the courses that you completed that meet the above required hours. Additional course descriptions and syllabi may be required if the Board is not able to identify subject matter based on the name of the class.

4. Clinical Training Practicum Form (TN-PSY FORM) completed by your clinical training program director. The program must verify completion of 36 credit hours of rotations completed within a minimum of 14 months and a maximum of 28 months. A minimum of 1,620 clock hours of clinical rotation training must be completed.

5. Proof of passage of the Psychopharmacology Examination for Psychologists (PEP). Examination scores must be submitted directly to the Department by the Association of State and Provincial Psychology Boards (ASPPB). To register, please visit www.psypro.org. For more information, refer to the PEP Candidate Handbook at www.asppb.net/pepexam.

(DO NOT USE THIS APPLICATION FOR RENEWAL OF AN EXISTING LICENSE)

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

APPLICATION FOR PRESCRIBING PSYCHOLOGIST

A CURRENT ILLINOIS CLINICAL PSYCHOLOGIST LICENSE IS REQUIRED FOR PRESCRIBING PSYCHOLOGIST LICENSURE

The following materials are required to make application for a Prescribing Psychologist license in Illinois:

1. APPLICATION FOR PRESCRIBING PSYCHOLOGIST LICENSURE.
2. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
3. If the name shown on your supporting documents is different from that shown on your application, you must submit PROOF OF LEGAL NAME change - copy of marriage license, divorce decree, affidavit or court order.

A. Type or print legibly with black ink only.

B. Fees are below - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE!

C. Disclosure of your U.S. Social Security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65. The Social Security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	FEE
Prescribing Psychologist	**074**	**Acceptance of Examination**	**$150**
		Endorsement	**$100**

4. INDICATE YOUR CURRENT ILLINOIS CLINICAL PSYCHOLOGIST LICENSE NUMBER: **071-** _____

PART II: Applicant Identifying Information

1. NAME — LAST — FIRST — MIDDLE

3. SSN OR ITIN: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

4. PERMANENT MAILING ADDRESS — CITY — STATE/COUNTRY — ZIP CODE — COUNTY

ZIP CODE: ___ ___ ___ ___ ___ + ___ ___ ___ ___

5. MAIDEN, GIVEN, OR OTHER USED NAME(S)

6. PLACE OF BIRTH (CITY, STATE/COUNTRY)

7. DATE OF BIRTH: ___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)

8. ☐ Female ☐ Male

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

Home: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

Fax: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___ (Area Code)

E-MAIL ADDRESS (REQUIRED) _____

PART III: Education Information

1. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	TYPE OF DEGREE EARNED

2. SUPERVISED CLINICAL TRAINING

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM (Month/Year)	DATES OF ATTENDANCE TO (Month/Year)	Did You Complete Training?
				☐ Yes ☐ No
				☐ Yes ☐ No

Additional application forms can be downloaded from the IDFPR Web site at idfpr.illinois.gov

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

PART IV: Record of Licensure Information

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, you are instructed to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however; certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS
State of Original Licensure				(Active, Lapsed, etc.)
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

PART V: Record of Examination - List Psychopharmacology Examinations.

NAME OF EXAMINATION	MONTH/YEAR	EXAM RESULTS (Passed, Failed, Absent)

CERTIFYING AGENCY

PART VI: Personal History Information *(This part must be completed by all applicants)*

	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
4. Do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Has any previous registration held by you under the Illinois Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? *If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.*		

PART VII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? ☐ Yes ☐ No
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? ☐ Yes ☐ No

3. In accordance with 20 ILCS 2105/2105-15(g-5), "The Department shall refuse the issuance or renewal of a license to, or suspend or revoke the license of, any individual, corporation, partnership, or other business entity that has been found by the Illinois Workers' Compensation Commission or the Department of Insurance to have failed to secure workers' compensation obligations, or pay in full a fine or penalty imposed due to a failure to secure workers' compensation obligations."

   Are you delinquent in complying with workers' compensation obligations? ☐ Yes ☐ No

PART VIII: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete. **I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.**

Signature of Applicant _____ Date _____

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION PRESCRIBING PSYCHOLOGIST

SUPPORTING DOCUMENT

ED - RxPsy

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. PROFESSION: **074 Prescribing Psychologist (RxPsy)**	
6. MAIDEN OR GIVEN SURNAME	☐ **Undergraduate Biomedical Coursework** ☐ **Graduate Level Didactic Coursework**	
7. NAME OF INSTITUTION ATTENDED	8. DATE OF GRADUATION / COMPLETION __ __ / __ __ / __ __ __ __ Month Day Year	

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date _____ Signature of Applicant _____

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION	B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
C. DEPARTMENT OF INSTITUTION	D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT
E. MAJOR AREA OF STUDY OF THE APPLICANT	F. APPLICANT WAS (CHECK ONE): ☐ Full-time ☐ Part-time ☐ Co-op
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) ☐ _____ Semester Hours ☐ _____ Quarter Hours ☐ _____ Course Hours	H. DATES OF ATTENDANCE From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __ Month Day Year Month Day Year
I. Total academic years attended _____ _____ _____ Years Months Days **OR** Total calendar years attended _____ _____ _____ Years Months Days	J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., M.A., M.D., Psy.D., Ph.D., None)
K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET __ __ / __ __ / __ __ __ __ Month Day Year	L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED __ __ / __ __ / __ __ __ __ Month Day Year

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

☐ Applicant has graduated on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant has completed program on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant will graduate on __ __ / __ __ / __ __ __ __ (Month Day Year)

☐ Applicant will complete program on __ __ / __ __ / __ __ __ __ (Month Day Year)

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

All applicants must complete a minimum of 3 semester credit hours or equivalent quarter hours in each of the following UNDERGRADUATE level biomedical and GRADUATE level didactic core areas. In the table below, list specific coursework completed by the applicant in each of the required core areas. Include BOTH the UNIT of credit and the AMOUNT of credit awarded. For Semester Hours, abbreviate "SH". For Quarter Hours, abbreviate "QH". For all other units of credit please include information about conversion to semester hours. (_____ = 3 semester hours.) Please refer to Rules 68 IAC Section 1400.200 (a) for more information about each core area.

Do not include courses that do not fit the required core areas. If no course was completed in a specific core area, mark "NONE". If no credit was awarded, mark "ZERO". Attach additional pages if necessary. **Failure to complete this section of the application correctly may result in licensure delays for the applicant.**

UNDERGRADUATE BIOMEDICAL COURSEWORK	COURSE TITLE	COURSE NO.	YEAR	COURSE CREDIT
Medical Terminology				
Chemistry or Biochemistry with Lab (2 semesters)				
Human Physiology				
Human Anatomy				
Anatomy and Physiology				
Microbiology with Lab				
General or Cell & Molecular Biology				

GRADUATE DIDACTIC COURSEWORK	COURSE TITLE	COURSE NO.	YEAR	COURSE CREDIT
Pharmacology				
Clinical Psychopharmacology				
Clinical Anatomy & Integrated Science				
Patient Evaluation				
Advanced Physical Assessment				
Research Methods				
Advanced Pathophysiology				
Diagnostic Methods				
Problem Based Learning				
Clinical and Procedural Skills				

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _____ , 20____.

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION OF CLINICAL TRAINING**	SUPPORTING DOCUMENT **TN-PSY**

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. MAIDEN OR GIVEN SURNAME	

CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed _____ months of full time, supervised clinical training in _____
(Name of Specialty Program)

from _____ to _____ at the following facility:
MM/DD/YYYY **MM/DD/YYYY**

Facility: _____

Number and Street: _____

City, State and Zip Code: _____

Transcripts must indicate that the applicant completed rotations in emergency medicine, family medicine, geriatrics, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, surgery and one elective program. Completion of at least 36 credit hours of rotaions with a minimum of 1,620 clock hours must be verified.

I further certify that at the time of such training the program was accredited by:

☐ the APA

☐ * Equivalent approved doctoral or pre-doctoral program

☐ * Equivalent postdoctoral Master's program

** If program is not APA approved, additional documentation may be requested.*

Name of Clinical Training Program Director: _____

Signature of Clinical Training Program Director: _____

Date of this Certification: _____

Telephone No: _____

University/Hospital
S E A L

(If no seal, attach letter on letterhead stating no seal exists.)