INSTRUCTION / INFORMATION SHEET

ADVANCED PRACTICE NURSE (Profession Code - 209)

- Certified Nurse Midwife
- Certified Clinical Nurse Specialist
- Certified Nurse Practitioner
- Certified Registered Nurse Anesthetist

In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.

Note: A CURRENT ILLINOIS REGISTERED NURSE LICENSE IS REQUIRED FOR ADVANCED PRACTICE NURSE LICENSURE.

Before completing the application package, please read the following.

APPLICATION FOR ADVANCED PRACTICE NURSE LICENSURE

- ☐ **Part I, Box 5, page 1 -** Specify the category of advanced practice nursing for which your are applying. A separate fee **and application is required for each category.**
- ☐ **Part I, Box 6, page 1** - Indicate your current Illinois Registered Nurse License Number.
- ☐ **Part II-VIII, pages 1 and 2** - Complete all applicable information requested in pages 1 and 2.

APN LICENSURE REQUIREMENTS

- ☐ Specific instructions for each category of advanced practice nursing for which you are applying are located on the following pages.
- ☐ Locate the instructions for specific category you selected in **Part 1, Box 5 of the Application for Advanced Practice Nurse Licensure** and follow those instructions only.

ASSISTANCE IN COMPLETING APPLICATIONS

- ☐ If you need assistance in completing the application, you may call 1-800-560-6420 or (TTY) 1-866-325-4949. Inform the operator that you are applying for Advanced Practice Nurse Licensure and that you would like assistance in completing your application.

APPLICATION FEE

- ☐ The APN application fee is **$125**. A separate fee and application are required for each category of licensure. 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 NOT REFUNDABLE.**

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, Illinois 62791

APPLICATION LICENSURE EXPIRATION

- ☐ The application, which you submit, is valid for three (3) years from the date of receipt.
- ☐ All Illinois Advanced Practice Nurse licenses will expire on May 31 of every even-numbered year.

MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCE LICENSE

- ☐ If you have been delegated prescriptive authority to prescribe Schedule II, 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

- ☐ These do not need to be forwarded to the Department with your application.

TEMPORARY PERMIT

- ☐ To apply for a Temporary Permit, see instructions on page 5

RESTORATION

- ☐ To apply for Restoration, see instructions on page 5

The Illinois Nurse Practice Act and Rules and additional application forms for Advanced Practice Nurse Licensure and for the Mid-level Practitioner Controlled Substance License can be downloaded from the IDFPR Web site at: www.idfpr.illinois.gov

CERTIFIED NURSE MIDWIFE

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. Supporting Document **CT-APN** completed by the state in which you were originally licensed, current state of licensure and any other state in which you have been actively practicing as an advanced practice nurse within the last 5 years. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return the completed form to you to submit with your licensure application.

3. A current copy of your national certification (certification or pocket card accepted) from one of the following:

   - The American College of Nurse Midwives (ACNM); **OR**
   - The American College of Nurse Midwives Certification Council (ACC)

4. Official transcripts with school seal affixed to substantiate proof of successful completion of a graduate degree appropriate for national certification in the clinical advanced practice nursing specialty category of certified nurse midwife or graduate degree or post-master's certificate from a graduate level program in the clinical advanced practice nursing specialty category of certified nurse midwife. If CNM certification was obtained outside of a masters (or higher) program, submit this transcript in addition to your master's transcript.

CERTIFIED NURSE PRACTITIONER

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. Supporting Document **CT-APN** completed by the state in which you were originally licensed, current state of licensure and any other state in which you have been actively practicing as an advanced practice nurse within the last 5 years. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return the completed form to you to submit with your licensure application.

3. A current copy of your national certification (certification or pocket card accepted) from one of the following:

   - American Academy of Nurse Practitioners Certification Program as a Nurse Practitioner
   - American Nurses Credentialing Center as a Nurse Practitioner
   - The Pediatric Nurse Certification Board as a Nurse Practitioner
   - The National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties as a Nurse Practitioner
   - The Certification Board for Urologic Nurses and Associates as a Urologic Nurse Practitioner.

4. Official transcripts with school seal affixed to substantiate proof of successful completion of a graduate degree appropriate for national certification in the clinical advanced practice nursing specialty category of certified nurse practitioner or a graduate degree or post-master's certificate from a graduate level program in the clinical advanced practice nursing specialty category of certified nurse practitioner.

CERTIFIED CLINICAL NURSE SPECIALIST

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. Supporting Document **CT-APN** completed by the state in which you were originally licensed, current state of licensure and any other state in which you have been actively practicing as an advanced practice nurse within the last 5 years. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return the completed form to you to submit with your licensure application.

3. A current copy of your national certification (certification or pocket card accepted) from one of the following:

- American Nurses Credentialing Center (ANCC)
  - Clinical Nurse Specialist
  - Clinical Specialists in Community Health Nursing
  - Clinical Specialists in Gerontology Nursing
  - Clinical Specialists in Home Health Nursing
  - Clinical Specialists in Pediatric Nursing
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adults
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adolescent
  - Psychiatric and Mental Health Nursing
  - Cardiac and Vascular Nurse
  - College Health Nurse
  - Perinatal Nurse
  - Ambulatory Care Nursing
  - Diabetes
- American Association of Critical Care Nurses as a Clinical Nurse Specialist
- Rehabilitation Nursing Certification Board as a Certified Rehabilitation Registered Nurse--Advanced
- Oncology Nursing Certification Corporation as an Advanced Oncology Certified Nurse (AOCN)
- Certification Board for Urologic Nurses and Associates as a Urologic Clinical Nurse Specialist.
- American College of Cardiovascular Nursing
- American Association of Critical Care Nurses
- American Association of Neuroscience Nurses
- American Board of Occupational Health Nurses, Inc.
- American Holistic Nurses Association
- American Society of Perianesthesia Nurses
- American Society of Plastic Reconstructive Surgical Nurses
- Association of Nurses in AIDS Care
- Board of Certification of Emergency Nurses
- Certification Board of Perioperative Nurses, Inc.
- Certification of Pediatric Oncology Nurses
- Certification Board of Gastroenterology Nurses
- Dermatology Certification Board
- International Board of Lactation Consultants
- International Nurses Society of Addictions
- IV Nurses Certification Corporation
- National Association of School Nurses, Inc.
- National Board of Certification of Hospice and Palliative Nurses
- National Certification Board for Diabetes Educators
- National Certification Board of Pediatric Nurse Practitioners/Nurses
- National Certification Corporation for the Obstetric, Gynecological and Neonatal Nursing Specialties
- National Certifying Board for Ophthalmic Registered Nurses
- Nephrology Nursing Certification Board
- Oncology Nursing Certification Corporation
- Orthopedic Nurses Certification Board
- Rehabilitation Nursing Certification Board
- Vascular Nursing Certification Board
- Wound, Ostomy, and Continence Society

4. Official transcripts with school seal affixed to substantiate proof of successful completion of a graduate degree appropriate for national certification in the clinical advanced practice nursing specialty category of clinical nurse specialist or a graduate degree or post-master's certificate from a graduate level program in the clinical advanced practice nursing specialty category of clinical nurse specialist.

CERTIFIED REGISTERED NURSE ANESTHETIST

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. Supporting Document **CT-APN** completed by the state in which you were originally licensed, current state of licensure and any other state in which you have been actively practicing as an advanced practice nurse within the last 5 years. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return the completed form to you to submit with your licensure application.

3. A current copy of your national certification (certification or pocket card accepted) from one of the following:
   - Council on Certification of the American Association of Nurse Anesthetists; **or**
   - Council on Recertification of the American Association of Nurse Anesthetists.

4. Official transcripts with school seal affixed to substantiate proof of successful completion of a graduate degree appropriate for national certification in the clinical advanced practice nursing specialty category of certified registered nurse anesthetist or a graduate degree or post-master's certificate from a graduate level program in the clinical advanced practice nursing specialty category of certified registered nurse anesthetist.

FOR APPLICANTS WHO DO NOT HAVE A GRADUATE DEGREE MAKING APPLICATION BEFORE JULY 1, 2018

- Official transcripts with the school seal affixed indicating successful completion prior to January 1, 1999, of a post-basic advanced practice formal education program in the area of **nurse anesthesia**.

- Supporting document **WH** must be completed indicating the five (5) year period immediately preceding the date of your application.

SPECIAL INSTRUCTIONS FOR APPLICANTS SEEKING LICENSURE IN MORE THAN ONE ADVANCED PRACTICE NURSING CATEGORY

Applicants seeking licensure in more than one advanced practice nursing category may apply for licenses for multiple advanced practice nurse licensure categories if the applicant has met the requirements for at least one advanced practice nursing specialty; and

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

2. Submits proof in the form of official transcripts with the school seal affixed that he/she possesses an additional graduate education that results in a certificate for another clinical advanced practice nurse category and that meets the requirements for the national certification from the appropriate nursing specialty; and

3. He/she submits a copy of a current, national certification from the appropriate certifying body for that additional advanced practice nursing category.

TEMPORARY PERMIT

Pursuant to Section 65-10 of the Illinois Nurse Practice Act, you may be eligible to receive a temporary permit. The temporary permit is valid for six months from the date of issuance, or issuance of an Illinois Advanced Practice Nurse license in your specialty area, or notification that the Department intends to deny licensure, whichever comes first. It will be your responsibility to complete the APN licensure process **prior** to the expiration of the temporary permit. Temporary practice does not include "prescriptive authority."

In order to receive the permit, submit the following forms and documentation:

1. Supporting Document PHQ **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Two-page Application for Advanced Practice Nurse Licensure.
3. TP-APN Form (Temporary Permit).
4. Documentation from an approved certifying body indicating the date you are scheduled to sit for the examination in the area of your nursing specialty.
5. Fee--Combine the APN licensure fee of $125 and the temporary permit fee of $25 into one check or money order. Total fee is $150.

RESTORATION

In order to restore an APN license that has been expired on been placed on inactive status for more than five years, submit the following documentation:

1. Supporting Document PHQ **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Application for Licensure and/or Examination (four page);
3. RS Form (Restoration) – If this form is not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 1-800-560-6420;
4. CT-APN (Certification of Licensure) Form competed by the state of licensure where you have been practicing within the last five (5) years; OR an affidavit attesting to military service as provided in Section 65-20 of the Nurse Practice Act;
5. Proof of completion of 80 hours of approved continuing education credits completed in the two years prior to the date of the restoration application (copies of certificates are acceptable); and
6. Proof of continued, current national certification in your specialty (copy of your current national certification is acceptable).

Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation. (See the Official Use Only Box on supporting document RS (Restoration), for the fee amount you must submit.)

All documents, forms and fee must be submitted to the following address:

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

IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966."**

"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse."**

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Advanced Practice Nurse

In order for your application to be processed,
<u>ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED</u>
with the application and required fee unless otherwise directed in the instructions.

Before you mail your application, check the following items to make sure your application is complete!

TWO-PAGE APPLICATION REVIEW		**COMPLETED**
Part I.	Application Category Information	
Part II.	Applicant Identifying Information	
Part III.	Education Information	
Part IV.	Record of Licensure Information	
Part V.	Record of Examination	
Part VI.	Personal History Information	
Part VII.	Child Support and/or Student Loan Information	
Part VIII.	Certifying Statement--Signed and Dated	

SUPPORTING DOCUMENTS	**SUBMITTED**
2-page Application for Licensure and/or Examination	
Application Fee--$125;	
Temporary Permit Fee--Additional $25	
Supporting Document PHQ **<u>must</u>** be completed and submitted with each application. Your application will not be processed without completion of this form.	
OFFICIAL TRANSCRIPTS OF ADVANCED PRACTICE NURSING-- with school seal affixed.	
CT-APN (Certification of Licensure) Form completed by state of original licensure, state of current licensure where you have been practicing within the last five (5) years.	
CURRENT COPY OF NATIONAL CERTIFICATION	
TP-APN (Temporary Permit)--if applicable	
RS Form (Restoration only)	

All supporting documents *<u>may not be required</u>*. Please refer to application instructions for your specific method of licensure.

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.

WORK HISTORY

SUPPORTING DOCUMENT

WH

APPLICANT: Complete Work History. If you have never been employed you may stop at box 8. You are authorized to photocopy this form if additional space is required.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. _____ Profession Name ___ ___ ___ Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED. ☐	8. DATE FORM COMPLETED

9. RECORD WORK HISTORY CHRONOLOGICALLY - Complete Work History beginning with present employment and concluding with graduation. You must account for the entire time period including periods of unemployment and volunteer work, etc.

A. NAME OF BUSINESS / INSTITUTION		JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

B. NAME OF BUSINESS / INSTITUTION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME		
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

C. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY , STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY , STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

SUPERVISOR NAME

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

(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 ADVANCED PRACTICE NURSE LICENSURE

A CURRENT ILLINOIS REGISTERED NURSE LICENSE IS REQUIRED FOR ADVANCED PRACTICE NURSE LICENSURE

The following materials are required to make application for an Advanced Practice Nursing license in Illinois:

1. APPLICATION FOR ADVANCED PRACTICE NURSE 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. The fee is $125 - Make check payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE! (Separate application/fee is required for each category of APN licensure.)

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	4. FEE
Advanced Practice Nurse	**2 0 9**	**Non-examination**	**$125**

5. CHECK ONE OF THE FOLLOWING BOXES INDICATING THE CATEGORY OF ADVANCED PRACTICE NURSE:

☐ Certified Clinical Nurse Specialist ☐ Certified Registered Nurse Anesthetist
☐ Certified Nurse Practitioner
☐ Certified Nurse Midwife

6. INDICATE YOUR CURRENT ILLINOIS REGISTERED NURSE LICENSE NUMBER:
041-

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., APN Specialty)

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

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

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	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
		Month/Year	Month/Year	

2. ADVANCED PRACTICE NURSE SPECIALITY TRAINING (Include, even if same as number 1.)

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

Additional application forms can be downloaded from the IDFPR Web site at www.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 - Record any examination you have taken in the category of Advanced Practice Nursing which you checked in PART I, Box 5, above.

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 certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*		
2. Have you had or 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 of whether or not you are currently under treatment.*		
3. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? *If yes, attach a detailed explanation.*		
4. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? *If yes, attach a detailed explanation.*		

PART VII: Child Support and/or Student Loan 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 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? ☐ 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.

Signature of Applicant _____ Date _____

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 20 ILCS 2105 of the Civil Administrative Code. Disclosure of this information is REQUIRED.

HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS

SUPPORTING DOCUMENT

PHQ

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)
___ - ___ ___ ___ ___

4. SOCIAL SECURITY NUMBER OR ITIN
___ ___ - ___ ___ - ___ ___ ___

Pursuant to 20 ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding charges or convictions pertaining to certain offenses. **Please check applicable profession.**

- ☐ Acupuncturist
- ☐ Advanced Practice Registered Nurse
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainer
- ☐ Audiologist
- ☐ Behavior Analyst
- ☐ Behavior Analyst Assistant
- ☐ Certified Midwife
- ☐ Chiropractic Physicians (D.C.)
- ☐ Dental Hygienist
- ☐ Dentist
- ☐ Genetic Counselor
- ☐ Licensed Practical Nurse
- ☐ Marriage and Family Therapist
- ☐ Marriage and Family Therapist Assoc.
- ☐ Music Therapist
- ☐ Naprapath
- ☐ Nursing Home Administrator
- ☐ Occupational Therapist
- ☐ Occupational Therapy Assistant
- ☐ Optometrist
- ☐ Orthotist
- ☐ Pedorthist
- ☐ Perfusionist
- ☐ Pharmacist
- ☐ Physical Therapist
- ☐ Physical Therapy Assistant
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.)
- ☐ Physician Assistant
- ☐ Professional Counselor (LPC)
- ☐ Professional Counselor, Clinical (LCPC)
- ☐ Psychologist, Clinical (LCP)
- ☐ Podiatrist
- ☐ Prosthetist
- ☐ Registered Nurse
- ☐ Registered Surgical Assistant
- ☐ Registered Surgical Technologist
- ☐ Respiratory Care Practitioner
- ☐ Sex Offender Associate
- ☐ Sex Offender Evaluator
- ☐ Sex Offender Treatment Provider
- ☐ Social Worker (LSW)
- ☐ Social Worker, Clinical (LCSW)
- ☐ Speech Pathologist

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

	Yes	No
1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *	☐	☐
2) Are you currently charged with or have you been convicted of a criminal battery against any patient *in the course of patient care or treatment*, including any offense based on sexual conduct or sexual penetration?	☐	☐
3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *	☐	☐
4) Are you currently charged with or have you been convicted of a forcible felony? *	☐	☐

*If **YES** to any of the above, attach a personal statement describing the circumstances of the charge or conviction and a certified copy of the court records regarding your charge or conviction, including the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant _____ Email _____ Date _____

* DEFINITIONS

730 ILCS 150 et. seq:—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

11-20.1 (child pornography),
11-20.3 (aggravated child pornography),
11-6 (indecent solicitation of a child),
11-9.1 (sexual exploitation of a child),
11-9.2 (custodial sexual misconduct),
11-9.5 (sexual misconduct with a person with a disability),
11-15.1 (soliciting for a juvenile prostitute),
11-18.1 (patronizing a juvenile prostitute),
11-17.1 (keeping a place of juvenile prostitution),
11-19.1 (juvenile pimping),
11-19.2 (exploitation of a child),
11-25 (grooming),
11-26 (traveling to meet a minor),
12-13 (criminal sexual assault),
12-14 (aggravated criminal sexual assault),
12-14.1 (predatory criminal sexual assault of a child),
12-15 (criminal sexual abuse),
12-16 (aggravated criminal sexual abuse),
12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

10-1 (kidnapping),
10-2 (aggravated kidnapping),
10-3 (unlawful restraint),
10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
11-6.5 (indecent solicitation of an adult),
11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
11-16 (pandering, if the victim is under 18 years of age),
11-18 (patronizing a prostitute, if the victim is under 18 years of age),
11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A **"forcible felony"**, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

a) First Degree Murder (Section 9-1);
b) Intentional Homicide of an Unborn Child (Section 9-1.2);
c) Second Degree Murder (Section 9-2);
d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
e) Drug-induced Homicide (Section 9-3.3);
f) Kidnapping (Section 10-1);
g) Aggravated Kidnapping (Section 10-2);
h) Unlawful Restraint (Section 10-3);
i) Aggravated Unlawful Restraint (Section 10-3.1);
j) Forcible Detention (Section 10-4);
k) Involuntary Servitude (Section 10-9(b));
l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
m) Trafficking in Persons (Section 10-9(d));
n) Criminal Sexual Assault (Section 11-1.20);
o) Aggravated Criminal Sexual Assault (Section 11-1.30);
p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
q) Criminal Sexual Abuse (Section 11-1.50);
r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
s) Aggravated Battery (Section 12-3.05);
t) Compelling Organization Membership of Persons (Section 12-6.5);
u) Compelling Confession or Information by Force or Threat (Section 12-7);
v) Home Invasion (Section 12-11);
w) Robbery (Section 18-1);
x) Armed Robbery (Section 18-2);
y) Vehicular Hijacking (Section 18-3);
z) Aggravated Vehicular Hijacking (Section 18-4);
aa) Aggravated Robbery (Section 18-5);
bb) Terrorism (Section 29D-14.9);
cc) Causing a Catastrophe (Section 29D-15.1);
dd) Possession of a Deadly Substance (Section 29D-15.2);
ee) Making a Terrorist Threat (Section 29D-20);
ff) Falsely Making a Terrorist Threat (Section 29D-25);
gg) Material Support for Terrorism (Section 29D-29.9);
hh) Hindering Prosecution of Terrorism (Section 29D-35);
ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
jj) Armed Violence (Section 33A-2); and
kk) Attempt (Section 8-4) of any of the above specified offenses.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFICATION BY LICENSING AGENCY/BOARD**	SUPPORTING DOCUMENT **CT-APN**

APPLICANT: Complete the applicant section of this form then forward this form to the state or territory in which you are requesting certification of your Advanced Practice Nurse license. Contact certifying jurisdiction for appropriate fee. Photocopying this form is permissible.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN _ _ _ - _ _ - _ _ _ _
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. _____ ___ ___ ___ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (__ __ __) _ _ _ - _ _ _ _	
7a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	7b. LICENSE NUMBER (If applicable)	7c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ to furnish to the Illinois Department of
Name of Licensing Agency or Board
Financial and Professional Regulation or its designated testing service, the information requested below.

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: Complete the remainder of this form. Please record N/A in areas which are not applicable.

PART I. - CERTIFICATION OF ADVANCED PRACTICE NURSE LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

☐ Examination - Date _____
☐ Endorsement of License (State) _____
☐ Administered in Another State _____
☐ Waiver/Grandfather _____
☐ Other (Describe) _____
_____

F. CURRENT LICENSURE STATUS

☐ Active
☐ Inactive
☐ Lapsed _____
☐ Other (explain) _____

PART II. - FORMAL ACTION

A. Is there now or has there ever been any formal action commenced against the applicant? ☐ Yes ☐ No

B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** ☐ Yes ☐ No

PART V. - ADDITIONAL INFORMATION

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

I certify that the information contained herein is true and correct according to the official records of the State.

Print Name

Title

Signature

S E A L

Agency/Board Street Address

Date

Area Code ( )

City, State, ZIP Code

Telephone Number

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

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

ADVANCED PRACTICE NURSE TEMPORARY PERMIT

SUPPORTING DOCUMENT

TP-APN

APPLICANT: ***This form must be completed in its entirety and accompanied by the two (2) page application.***

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH

__ __ / __ __ / __ __ __ __
Month Day Year

3. SSN OR ITIN

_ _ _ - _ _ - _ _ _ _

4. ADDRESS STREET, CITY, STATE, ZIP CODE

6. MAIDEN OR GIVEN SURNAME

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

ADVANCED PRACTICE NURSE — Profession Name

2 0 9 — Profession Code

7. Advanced Practice Nurse Specialty Training

Name of Institution	Location of Program (City and State)	Type of Degree Earned

8. National Certifying Examination Information:

Record of Examination - Record any examination you are scheduled for or have taken in the category of Advanced Practice Nursing which you checked in Part 1, Box 5, or the two-page Application for Advanced Practice Nurse Licensure.

NAME OF EXAMINATION	DATE OF EXAMINATION

9. Have you been convicted of any crime under the laws of any jurisdiction of the United States: (a) which is a felony; or (b) which is a misdemeanor directly related to the practice of the profession within the last five (5) years?

☐ Yes No ☐ If so, submit certified copies of all court records pertaining to said conviction.

10. Have you had a license or permit related to the practice of nursing revoked, suspended, or placed on probation by another jurisdiction within the last five (5) years? Yes ☐ No ☐

If so, have appropriate board of nursing complete CT-NUR form and attach copies of disciplinary action.

I certify the information and documents contained in this application are true and correct to the best of my knowledge. I understand should any of the information or documents contained herein be proven false, it may result in the denial of my Temporary Permit request and/or permanent endorsement/restoration application or other appropriate disciplinary action.

_____ _____

Signature Date

CERTIFYING STATEMENT BY COLLABORATING PHYSICIAN

Under penalties of perjury, I declare that I, _____ , have entered into a
(Print Name of Collaborating Physician)

proposed Advanced Practice Nursing Written Collaboration Agreement with _____,
(Advanced Practice Nurse)

effective this date (month/day/year): _____ .

Illinois License of Collaborating Physican: _____

Signature of Collaborating Physician:_____

Written Collaborative Agreements need not be forwarded to the Department.

INFORMATION SHEET

PRESCRIPTIVE AUTHORITY
FOR ADVANCED PRACTICE NURSE MID-LEVEL PRACTITIONER

Pursuant to Section 1300.430 of the Rules for the Administration of the Illinois Nurse Practice Act: *A collaborating physician who delegates limited prescriptive authority to an advanced practice nurse shall include such delegation in the written collaborative agreement. The prescriptive authority may include prescription and dispensing of legend drugs and controlled substances categorized as Schedule II, III, IV, or V controlled substances, as defined in the Illinois Controlled Substances Act. An APN who has been given controlled substances prescriptive authority shall be required to obtain a mid-level practitioner controlled substances license in accordance with 77 Ill. Admin. Code Part 3100. The physician shall file a notice of delegation of prescriptive authority with the Department. The delegation of authority form shall be submitted to the Department prior to the issuance of a controlled substances license. The APN may only prescribe and dispense within the scope of practice of the collaborating physician. All prescriptions written and signed by an advanced practice nurse shall indicate the name of the collaborating physician. The collaborating physician's signature is not required. The advanced practice nurse shall sign his/her own name. An APN may receive and dispense samples per the collaborative agreement. Medication orders shall be reviewed periodically by the collaborating physician.*

If the collaborating physician has delegated prescriptive authority to the advanced practice nurse, the written collaborative agreement shall include a statement indicating the supervising physician has delegated prescriptive authority for legend drugs and/or Schedule II, III, IV, or V controlled substances. The collaborating physician may delegate authority for any or all of these schedules. The delegation must be within the physician's scope of practice and within the scope of the advanced practice nurse's training. The written collaborative agreement shall be signed by both the physician and the advanced practice nurse and a copy maintained at each location where the advanced practice nurse practices.

In addition to the requirements above, if the advanced practice nurse is delegated prescriptive authority of Schedule II controlled substances the following guidelines apply. Specific Schedule II controlled substances by oral dosage or topical or transdermal application may be delegated. This delegation must identify specific Schedule II controlled substance by either brand or generic name and must be attached to the collaborative agreement. Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated. Evidence of completion of at least 45 graduate contact hours in pharmacology must be submitted to obtain Schedule II prescriptive authority. The collaborating physician may only delegate controlled substances that he or she prescribes. Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician.

If the collaborating physician wishes to terminate the delegated prescriptive authority for Schedule II, III, IV, or V Controlled Substances, you are instructed to provide the collaborating physician with the Notice of Termination of Delegated Prescriptive Authority for Controlled Substances form for his/her completion. The form should be returned to the Department's Springfield address.

IN ORDER TO OBTAIN A MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCES LICENSE

The collaborating physician shall submit a notice of prescriptive authority indicating the advanced practice nurse has been delegated prescriptive authority. If the advanced practice nurse is collaborating with more than one physician, a separate notice of prescriptive authority shall be submitted by each collaborating physician. If prescriptive authority includes Schedule II, III, IV, or V controlled substances, the advanced practice nurse will be required to apply for a mid-level practitioner controlled substances license in accordance with the Illinois Controlled Substances Act.

The collaborating physician is required to complete the Notice of Delegated Prescriptive Authority for Controlled Substances, which must be on file with the Department, prior to the issuance of a mid-level practitioner's controlled substances license.

AUTHORITY TO PRESCRIBE OR DISPENSE LEGEND DRUGS

There is no form required to be filed with the Department to prescribe or dispense legend drugs. Any delegation for prescriptive authority for legend drugs should be included in the written collaborative agreement.

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

INSTRUCTIONS FOR ADVANCED PRACTICE NURSE MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCES LICENSE

******READ AND FOLLOW INSTRUCTIONS CAREFULLY******
FAILURE TO DO SO WILL DELAY ISSUANCE!

An Illinois advanced practice nurse mid-level practitioner controlled substances license may be issued to a licensed advanced practice nurse who has been delegated prescriptive authority by a collaborating physician for Schedule II, III, IV, and/or V controlled substances.

1. Supporting Document **PHQ <u>must</u>** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Complete Parts II through V of application and the supplemental documentation.
3. Submit the appropriate $5 licensure fee. Make check or money order payable to the Department of Financial and Professional Regulation. **Fee is not refundable**.
4. Return application, supporting documents and fee to the below noted Springfield, Illinois, address.
5. Failure to properly complete the application will delay licensure.
6. If applying for schedule II prescriptive authority, submit an official transcript with school seal affixed to document and completion of 45 graduate hours in pharmacology.

NOTE:

- A mid-level practitioner controlled substances license will not be issued until your advanced practice nurse license has been issued.
- If the collaborating physician has delegated prescriptive authority to the advanced practice nurse, the written collaborative agreement shall include a statement indicating that the collaborating physician has delegated prescriptive authority for legend drugs and/or Schedule II, III, IV, and V controlled substances. The delegation must be within the physician's scope of practice and within the scope of the advanced practice nurse's training.
- The written collaborating agreement shall be signed by both the physician and the advanced practice nurse and a copy maintained at each location where the advanced practice nurse practices and shall be provided to the Illinois Department of Financial and Professional Regulation upon request. A copy of the advanced practice nurse Illinois and federal controlled substances licenses numbers shall be kept with the agreement.
- If the advanced practice nurse is delegated prescriptive authority of Schedule II controlled substances the following guidelines apply. Specific Schedule II controlled substances by oral dosage or topical or transdermal application may be delegated. This delegation must identify specific Schedule II controlled substance by either brand or generic name and must be attached to the collaborative agreement. Schedule II controlled substances to be delivered by injection or other route of administration may not be delegated. Evidence of completion of at least 45 graduate contact hours in pharmacology must be submitted to obtain Schedule II prescriptive authority. The collaborating physician may only delegate controlled substances that he or she prescribes. Any prescription must be limited to no more than a 30-day supply, with any continuation authorized only after prior approval of the collaborating physician.
- **If collaborating with more than one physician, a separate notice of delegation of prescriptive authority shall be submitted when prescriptive authority is delegated**. If prescriptive authority includes Schedule II, III, IV and/or V controlled substances, the advanced practice nurse will be required to apply for a mid-level practitioner controlled substances license in accordance with the Illinois Controlled Substances Act; however, <u>only one controlled substances license will be issued regardless of the number of collaborating physicians</u>.

Should you have any questions relative to completing the application, contact:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786
1-800-560-6420

An Illinois advanced practice nurse mid-level practitioner controlled substances license is a **prerequisite** for federal controlled substances registration. For information concerning federal registration, you must contact:

Drug Enforcement Administration
230 South Dearborn, Suite 1200
Chicago, Illinois 60604
312/353-7875

Your Illinois advanced practice nurse mid-level practitioner controlled substances license number will expire at the same time your professional license expires.

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

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/301, et.seq. of the Illinois Compiled Statutes. Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

APPLICATION FOR ADVANCED PRACTICE NURSE MID-LEVEL PRACTITIONER ILLINOIS CONTROLLED SUBSTANCES LICENSE

1. An advanced practice nurse may only prescribe or dispense prescriptions or orders for drugs and medical supplies within the scope of practice of the collaborating physician.
2. An Illinois Advanced Practice Nurse Mid-Level Practitioner Controlled Substances License is a prerequisite to a Federal Mid-Level Practitioner Controlled Substances Registration (DEA).

A. Type or print legibly with black ink only.
B. The fee is $5 - 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 to obtain a license. 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.

Submit application and fee to:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

PART I: Application Category Information

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
Advanced Practice Nurse Mid-Level Practitioner Controlled Substances License	**309**	**Non-examination**	**$5**

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. ILLINOIS ADVANCED PRACTICE NURSE LICENSE NO. (If unknown, leave blank.)

3. SSN OR ITIN

___ – __ – ____

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

_____ + ____

5. **NAME AND LOCATION (STREET/CITY/ZIP CODE) WHERE ADVANCED PRACTICE NURSE MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED.**

IL _____ + ____

6. MAIDEN OR GIVEN SURNAME

7. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work (___) ___ – ____
Area Code

Home (___) ___ – ____
Area Code

8. E-MAIL ADDRESS (REQUIRED)

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

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

PART III: 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 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 IV: Child Support and/or Student Loan 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 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)

   Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes ☐ No ☐

PART V: Certifying Statement

I hereby apply for an Illinois Advanced Practice Nurse Mid-level Practitioner Controlled Substances License in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

Print Name of Applicant

Date of Application

Signature of Applicant

I UNDERSTAND THAT THE FEE IS NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.

Notice of Delegated Prescriptive Authority for Controlled Substances (Advanced Registered Practice Nurse)

APRN-CS

COLLABORATING PHYSICIAN:

Complete this form as official notification you are delegating prescriptive authority for controlled substances for the advanced practice nurse named herein. Email form to: fpr.nurseunit@illinois.gov or mail form to:

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor HSS - NURSE
Springfield, Illinois 62786

Upon your decision to terminate the delegated prescriptive authority for controlled substances for this individual, you must notify the Department of your intent by completing a Notice of Termination of Delegated Prescriptive Authority.

This notice, as well as other forms required for Advanced Practice Nurse Licensure and for the Mid-level Practitioner Controlled Substance License, can be downloaded from the IDFPR Web site at: www.idfpr.illinois.gov.

1. NAME OF ADVANCED PRACTICE NURSE (Last, First, Middle Initial)	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. **Advanced Practice Nurse Mid-level Practitioner Controlled Substances License** (Profession Name) **3 0 9** (Profession Code) 6. LICENSE NUMBER OF ADVANCED PRACTICE NURSE (If unknown, leave blank.)	
7. MAIDEN OR GIVEN SURNAME	8. APN CONTROLLED SUBSTANCE NUMBER	

This is to certify that I, _____, have delegated
(Collaborating Physician)

prescriptive authority to _____ in order to prescribe and/or
(Advanced Practice Nurse)

dispense controlled substances categorized as Schedule II, III, IV, or V controlled substances, as defined in Article II of the Illinois Controlled Substances Act. I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the advanced practice nurse's training. The advanced practice nurse named hereinabove may prescribe and/or dispense (please check appropriate box(es)):

Schedule(s) II ☐* III ☐ IV ☐ V ☐

Such delegation shall be in accordance with the provisions set forth in Section 303.05 a)2)B of the Illinois Controlled Substances Act.

_____
Print Name of Collaborating Physician

_____
Signature of Collaborating Physician

036 - _____
Illinois License Number of Collaborating Physician

336 - _____
Illinois Controlled Substance Number

_____
Date of Delegation of Prescriptive Authority

_____
Business Street Address of Collaborating Physician

_____
City, State, Zip Code

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

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.

Notice of Termination of Delegated Prescriptive Authority for Controlled Substances (Advanced Practice Nurse)

COLLABORATING PHYSICIAN: **Complete this form as official notification you are terminating the delegated prescriptive authority for controlled substances for the advanced practice nurse named herein and email form to *fpr.nurseunit@illinois.gov* or mail to:**

Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor HSS - NURSE
Springfield, Illinois 62786

This notice, as well as other forms required for Advanced Practice Nurse Licensure and for the Mid-level Practitioner Controlled Substance License, can be downloaded from the IDFPR Web site at: *www.idfpr.illinois.gov* .

1. ADVANCED PRACTICE NURSE NAME (Last. First, Middle)	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE		5. IL CONTROLLED SUBSTANCE LICENSE NUMBER OF ADVANCE PRACTICE NURSE: **309 -**

This is to certify that I, _____, hereby terminate the
(Collaborating Physician)

prescriptive authority delegated to _____ Illinois Licensed
(Advanced Practice Nurse)

Advanced Practice Nurse, License No. _____, effective _____ . This person is no longer delegated authority to prescribe and/or dispense controlled substances by this collaborating physician:

_____ _____
Print Name of Collaborating Physician Signature of Collaborating Physician

336 - _____
IL Controlled Substance License Number of Collaborating Physician

_____
Date of Termination of Prescriptive Authority

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

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

AUTHORIZATION FOR THIRD PARTY CONTACT

NURSING

Instructions to Applicant: Use this form to authorize individuals or companies (such as employers or credential services) to contact the Department on your behalf regarding your application.

Name:	Phone:
Address:	SSN or ITIN:
Profession:	Email:

I, _____, hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative:
Address:
Phone:
Email:

_____ _____

Applicant Signature Date

Completed forms may be sent to the Division at:

FPR.NurseUnit@illinois.gov