

# INSTRUCTION SHEET

## RN/LPN Reinstatement

*Please complete the following steps to reinstatement your RN or LPN license.*

### Step I - Application and Supporting Documents.

1. A completed **APPLICATION FOR REINSTATEMENT**.
2. A completed **Personal History Questionnaire (PHQ)**.
3. Submit **proof of 20 hours of Continuing Education (CE)** by submitting a copy of each CE completion certificate. Rosters are not acceptable.

Continuing Education credits must include the following:

- 1 hour of sexual harrassment training completed within the last two years
- 1 hour of Implicit Bias Awareness training completed after 01/01/2023
- 1 hour of training pertaining to Alzheimer's/Dementia completed after 01/01/2023

### STEP II - Fee

Identify the fee to reinstatement your license by using the Restoration/Reinstatement Fee Calculator.

Payment must be in the form of a check or money order payable to IDFPR, or by submitting a payment online using the ePay Portal at:

***<https://idfpr.illinois.gov/epay.html>***

### STEP III - Mail Application

Mail your application for reinstatement, supporting documents and payment to:

Illinois Department of Financial and Professional Regulation  
ATTN: Division of Professional Regulation  
PO Box 7450  
Springfield, IL 62791

### Need Assistance

If you need assistance, please contact the Department of Financial and Professional Regulation at:

1-800-560-6420 TTY: 1-866-325-4949



# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Request for Reinstatement of Illinois License

**PLEASE PRINT**

License No: \_\_\_\_\_ SSN or ITIN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(last four only)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Business Name: \_\_\_\_\_ FEIN #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

**CHECK HERE IF NAME OR ADDRESS CHANGE.** A name change must be accompanied by documentary proof. Proof must be a certified copy with an official stamp or seal and be one of the following: Marriage Certificate, Divorce Decree or Court Order.

I consent to professional organizations having my email address.

**Check the box indicating the appropriate information regarding your application.**

**Military**       **Military Spouse**       **Not Military**       **Decline to Answer**

Military service member is defined as. "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

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

4. Do you certify you have fully complied with this profession's continuing education requirements? Yes  No

*NOTE: Continuing education is not required for the first renewal of this license. If this is your first renewal, please answer (Yes) to this question.*

**Making a false statement may subject the licensee to disciplinary action.**

You may verify the continuing education requirements of your profession here: <https://idfpr.illinois.gov/rules2015.html>

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.**

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

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.

**If you selected a profession above, please complete the next 4 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? *  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? *  | <input type="checkbox"/> | <input type="checkbox"/> |

**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. I understand if I provide false/fraudulent information I could lose my license, be fined and/or have other penalties assessed. **I also understand the FEES ARE NOT REFUNDABLE.**

**Payment Method**

- Check / Money Order. Check Number: \_\_\_\_\_
- Online. Paid Online at: <https://idfpr.illinois.gov/epay.html> in the amount of \_\_\_\_\_. Approved #: \_\_\_\_\_

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Email

**INCOMPLETE REINSTATEMENT:** Incomplete forms will be returned and result in a substantial delay in the reissuance of your license. Please assure your reinstatement application is completed in full and includes the required fee and your signature. Fee must be a check or money order, payable to the IDFPR. Do not mail cash.