INSTRUCTION SHEET

RN/LPN

Restoration

Please use these instructions if your license has been on inactive status, or in a non-renewed status, for five (5) or more years.

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.

There are two ways to qualify for the restoration of your license:

1) If you have been lawfully practicing as an RN or LPN in another jurisdiction within the five (5) years immediately preceding submission of this application for restoration, you may submit verification of licensure in that jurisdiction to verify your lawful practice as well as other documentation outline in Section A.

OR

2) If you have not been practicing in another jurisdiction, you must complete NCLEX examination OR take a Department approved refresher course as well as other documentation outline in Section B.

Step I - Application

A. If your application is based upon LAWFUL PRACTICE in a state other than Illinois, you must submit all of the following:

1. A completed **APPLICATION FOR RESTORATION (REST).**

2. A completed **Personal History Questionnaire (PHQ).**

3. An official certification of licensure from your current state of licensure and all states you have actively practiced in the last 5 years. Obtain at ***www.nursys.com***. Request and pay for the official verification. The Quick-Confirm Report is not acceptable. If licensed in Pennsylvania, contact the Pennsylvania Board of Nursing to have an official certification of licensure sent to our department at: ***fpr.nurseunit@illinois.gov***.

4. Submit proof of **20 hours** of CEU taken within the last 2 years which must include:
   1 hour of sexual harassment training
   1 hour of Implicit Bias Awareness training
   1 hour of training pertaining to Alzheimer's/Dementia.
   ** Please submit a copy of each completion certificate. Rosters are not acceptable.

5. Complete background check and submit a copy of the receipt from the vendor who processed your fingerprints and complete the **Identity Verification Certificate Statement (OOS-FP)** form attached to the Fingerprint Background Check Guide.

B. <u>If you have not been actively practicing in the last 5 years you must submit all of the following:</u>

6. A completed **APPLICATION FOR RESTORATION (REST).**

7. A completed **Personal History Questionnaire (PHQ).**

8. If you have not been actively practicing in the last 5 years you will be required to retake the NCLEX examination OR take a Department approved refresher course. Please indicate your selection in the appropriate box on the Resatoration application.

9. Submit proof of **20 hours** of CEU taken within the last 2 years which must include:
   1 hour of sexual harrassment training
   1 hour of Implicit Bias Awareness training
   1 hour of training pertaining to Alzheimer's/Dementia.
   ** Please submit a copy of each completion certificate.
   * Rosters are not acceptable.

10. Complete background check and submit a copy of the receipt from the vendor who processed your fingerprints **OR** complete the **Identity Verification Certificate Statement (OOS-FP)** form attached to the Fingerprint Background Check Guide.

STEP II - Fee

Please use the Restoration/Reinstatement Fee Calculator to calculate your restoration fee.

Fee 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 restoration, 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

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.

APPLICATION FOR RESTORATION

SUPPORTING DOCUMENT

REST

APPLICANT: Complete this form, and **return it with the supporting documents and required payment.**

PART I: Application Category Information

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.

PART II: Application Identifying Information

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month Day Year)

3. SSN OR ITIN __ __ __-__ __-__ __ __ __

4. TELEPHONE NUMBER

WORK (__ __ __) __ __ __–__ __ __ __ (Area Code) HOME (__ __ __) __ __ __–__ __ __ __ (Area Code)

5. E-MAIL ADDRESS

☐ I consent to professional organizations having my email address.

6. ADDRESS STREET, CITY, STATE, ZIP CODE

7. Record profession name and three digit profession code for which you are making Illinois application.

______________________ Profession Name ___ ___ ___ Profession Code

8. MAIDEN OR GIVEN SURNAME

9. NAME AS IT APPEARS ON EXPIRED/INACTIVE LICENSE

10. ISSUANCE DATE OF EXPIRED OR INACTIVE LICENSE

11. DATE EXPIRED OR PLACED INACTIVE

12. EXPIRED OR INACTIVE LICENSE NUMBER

OFFICIAL USE ONLY

License No.: ______________ Fees: $ ___________

Issuance Date: ______________ On CRT: ☐Yes ☐No

PART III: Record of Licensure Information

LIST THE STATE(S) AND DATES WHERE YOU HAVE BEEN PRACTICING SINCE YOUR ILLINOIS LICENSE EXPIRED OR WAS PLACED ON INACTIVE STATUS. INCLUDE A BRIEF DESCRIPTION OF DUTIES PERFORMED.

STATE	NAME OF BUSINESS/INSTITUTION	DATES		DESCRIPTION OF DUTIES
		From	To	
		Mo/Yr	Mo/Yr	

PART IV: Statement of Restoration Method

Please refer to your restoration directions to determine if you need to complete this section.

If you are unable to restore your license based on lawful practice in another jurisdiction, then you must notify the Department that you wish to complete a refresher course or take and pass the Illinois exam that is specific to your profession.

Choose one of the options below, if applicable.

☐ I wish to take a refresher course specific to my profession. I will submit an official transcript from an approved school verifying successful completion of the required hours of instruction in the basic curriculum for the professional license I wish to restore. I understand that Illinois schools must be licensed by the Department and schools located outside of Illinois must be recognized and authorized to operate in the jurisdiction where the school is located.

☐ I wish to take the required examination specified in my profession's rules. I understand that upon receipt and processing of my restoration application, the Department will forward my application to the testing service. The Department will also e-mail to me an approval letter authorizing me to take the examination and providing instructions to register for the examination. DO NOT SUBMIT AN APPLICATION TO THE TESTING SERVICE UNTIL YOU ARE NOTIFIED BY THE DEPARTMENT.

PART V: 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. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? *If yes, attach a copy of the certificate.*		
4. Do you now have any disease or condition that presently limits 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? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. 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.*		
6. 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 VI: 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 ☐

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

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.**

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

NAME (Last, First, MI):

SSN OR ITIN:

Profession:

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	3. PROFESSIONAL LICENSE NUMBER (if any) ___ - _______
2. ADDRESS STREET, CITY, STATE, ZIP CODE	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 ____________

IMPORTANT NOTICE: Completion of this form is necessary for licensure/ employment under provision set forth within the Illinois Compiled Statutes or other related Federal laws. Disclosure of this information is VOLUNTARY. However, failure to comply may result in the denial of your application.	**IDENTITY VERIFICATION CERTIFYING STATEMENT**	**OOS-FP**

Pursuant to Title 68 Part 1240.535 of the Private Detective, Private Alarm, Private Security, Fingerprint Vendor, and Locksmith Act of 2004 Rules, fingerprint vendors are required to confirm identity of the individual seeking to be fingerprinted. This identity verification form must be completed for out-of-state residents applying for licensure/employment in the State of Illinois. This form will be utilized to confirm the personal identifying information being placed on the Illinois State Police (ISP) Fee Applicant fingerprint card, form number ISP-404. The out-of-state agency chosen to take your fingerprints, must complete this form, as written confirmation that a valid government issued drivers license or State ID was presented and that the identification provided, belongs to the individual being fingerprinted.

Instructions: This form must be submitted, along with a manual Fee Applicant fingerprint card to which your fingerprints have been applied, to a licensed live scan fingerprint vendor in the State of Illinois possessing "Scan Card" capability to ensure electronic transmission of the Fee Applicant fingerprint card. The electronic transmission of fingerprints to the ISP is mandated pursuant to Title 20 Part 1265 "Electronic Transmission of Fingerprints". **The manual submission of fingerprints to ISP is no longer acceptable.** Once your fingerprints have been taken, a signed original of this form must be attached to your Fee Applicant fingerprint card and submitted to an Illinois licensed live scan fingerprint vendor. As well, an additional copy may be required to be submitted to the requesting State Agency along with any additional application or required documentation specified by the State Agency.

Section 1 | Applicant Information (All fields mandatory)

LAST NAME:	FIRST:	MIDDLE:	PHONE NUMBER:
MAIDEN NAME/GIVEN SURNAME:	POSITION / REASON FINGERPRINTED: (NURSE/DOCTOR/SECURITY GUARD, ETC)		
ADDRESS: (STREET/CITY/STATE/ZIP)		DATE OF BIRTH:	SSN OR ITIN:

Section 2 | Certifying Agency Taking Fingerprints (Include TCN from Fee Applicant card)

AGENCY NAME:	TCN: FRM
DATE FINGERPRINT TAKEN: / /	CONTACT PHONE NUMBER: ( ) -
PRINTING AGENT'S NAME: LAST	FIRST

☐ I have compared the government issued identification presented by the applicant and attest that to the best determination, I have fingerprinted the same individual. (Must be checked to certify)

PRINTING AGENT'S SIGNATURE:

Illinois Live Scan Fingerprint Vendor Information

Section 3 | Fingerprint Vendor Agency Name

LIVE SCAN FP AGENCY NAME:	
REQUESTING STATE AGENCY:	REQUESTING STATE AGENCY ORI:
DATE FINGERPRINTS SUBMITTED TO ISP:	COST CENTER USED: