# INSTRUCTION SHEET

# NURSING HOME ADMINISTRATORS

**Non-Examination Temporary License**
**Examination**
**Endorsement of License**
**Restoration**

***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.***

**BEFORE COMPLETING THE APPLICATION PACKAGE**, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in accurately completing your application and eliminate any delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT. Except for temporary licenses, a license issued under the Nursing Home Administrator's Licensing and Disciplinary Act expires on November 30 of each odd-numbered year.

Step 1. Use the **REFERENCE SHEET (CHART I)** to select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, and record that information in **PART I** (page one) of the **Application for Licensure and/or Examination**.

Step 2. Proceed with **PART II** (page one) and complete all applicable information requested on all 4 pages of the **Application for Licensure and/or Examination**.

Step 3. The remainder of this form contains specific instructions for each Licensure Method. Locate the instructions for the Licensure Method you recorded in **PART I** (page one), of the **Application for Licensure and/or Examination** and follow those instructions only.

NOTE: All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, notarized translation that has been performed by a person, other than the applicant, who is fluent in both English and the language of the document(s). The translator shall certify to the above requirements as well as to the accuracy of the translation.

Step 4. If needed, telephone numbers for assistance in completing the Application Package are provided on the **REFERENCE SHEET**.

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

# EDUCATIONAL QUALIFICATIONS

***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.***

**ONE OF THE FOLLOWING EDUCATIONAL QUALIFICATIONS MUST BE MET IN ORDER TO BE ELIGIBLE TO SIT FOR EXAMINATION AND/OR RECEIVE A TEMPORARY LICENSE:**

1. Graduation from accredited college or university with minimum of BACCALAUREATE DEGREE; (Degree may be in any field. There is no experience requirement.)

OR

2. Satisfactory completion of an approved COURSE OF INSTRUCTION IN NURSING HOME ADMINISTRATION. (An approved course must include one course in Nursing Home Administration, Personnel Management, Accounting and Financial Management, and Social Gerontology. There is no experience requiremement).

OR

3. Graduation from a three year diploma nurse program and two years of QUALIFYING EXPERIENCE. (Verification of Qualifying Experience--Supporting Document **VE** must accompany application.)

OR

4. An associate degree or a minimum of 60 semester hours or 90 quarter hours of credit earned from an accredited college or university and QUALIFYING EXPERIENCE**.** (Verification of Qualifying Experience--Supporting Document **VE** must accompany application.)

OR

5. If applying by endorsement, may obtain a certification of completion of the Professional Certification Program for Nursing Home Administrators developed by the Foundation of the American College of Health Care Administrators.

**QUALIFYING EXPERIENCE**

Qualifying experience is defined as two years of full-time employment as an Assistant Nursing Home Administrator or Director of Nursing in a facility licensed by the Illinois Department of Public Health pursuant to the Nursing Home Care Act; OR two years of management experience in a corporation which owns and operates licensed nursing home facilities.

**FURTHER INSTRUCTIONS FOR APPLICANTS WHO ARE SUBMITTING EVIDENCE OF EDUCATION AND EXPERIENCE FOR A DETERMINATION OF EQUIVALENCY:**

1. In addition to documents listed above, you must also submit official college/university transcripts with school seal affixed.

NOTE: Your application and supporting documents may need to be reviewed by the Nursing Home Administrators Licensing and Disciplinary Board of the Department of Financial and Professional Regulation. In the event such review is necessary, you will not be scheduled for an examination until the review is completed and you have been determined eligible for examination.

# NON-EXAMINATION TEMPORARY LICENSE

***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.***

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

2. Supporting Document **ED** must be completed and have school seal affixed.

3. If applying on the basis of a three year diploma nurse or an Associate Degree and experience, Supporting Document **VE** must be completed.

4. Supporting Document **CA-NHA** must be completed by your employer.

5. Supporting Document **HL** must be completed by your examining physician and the examination must have occurred within one (1) year preceding your application. Those individuals applying for licensure pursuant to certification by a recognized church or religious denomination which teaches reliance on spiritual means alone for healing, must submit verification of membership with a recognized church or religious denomination which teaches reliance on spiritual means alone for healing. An applicant applying under this provision will be issued a Limited Nursing Home Administrator License which will allow the individual to be an administrator in an institution of the certifying church or denomination.

6. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.

7. Forward four-page application, supporting documentation and fee payment to the Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

NOTE: The holder of a Temporary License shall be authorized to serve as an administrator only for the facility indicated on the application. The Temporary License shall be valid only for the period of the time designated therein and may be extended only for one additional one-year period, if the applicant took the examination during the period of his or her Temporary License. An applicant may request an extension of a Temporary License if the applicant took the examination during the period of his or her temporary license by submitting a request in writing to the Department, along with a **CA-NHA** form completed by his or her employer, and a $20 processing fee which covers the cost of printing a new Temporary License. The original Temporary License must be returned with the request. The applicant shall retake the examination prior to the expiration of the extended Temporary License. A Temporary License as an administrator becomes void and shall be surrendered upon termination of the holder's service as an administrator to the facility for which the Temporary License was granted OR one year from the date of issuance, whichever comes first. No permanent license will be issued until the Temporary License has been returned to the Department. An individual shall be issued only one temporary license.

An applicant for a temporary license as a nursing home administrator may act as a nursing home administrator for a period of up to 60 days prior to the issuance of a license if the applicant has submitted the required fee and an application for licensure to the Department. This 60-day period may be extended until the next Board meeting if action by the Board is required. The applicant shall keep a copy of the submitted application on the premises where the applicant is engaged in the practice as a nursing home administrator.

The authority to practice shall terminate immediately upon the denial of licensure by the Department or the withdrawal of the application.

# EXAMINATION

***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: Any Temporary Nursing Home Administrator license must be returned to the Department prior to a permanent Nursing Home Administrator license being issued.**

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. If you have ever been licensed, Supporting Document **CT** must be completed by the U.S. jurisdiction of original licensure and the U.S. jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to you.
3. Supporting Document **HL** must be completed by your examining physician and the examination must have occurred within one (1) year preceding your application. Those individuals applying for licensure pursuant to certification by a recognized church or religious denomination which teaches reliance on spiritual means alone for healing, must submit verification of membership with a recognized church or religious denomination which teaches reliance on spiritual means alone for healing. An applicant applying under this provision upon successful completion of the examination will be issued a Limited Nursing Home Administrator License which will allow the individual to be an administrator in an institution of the certifying church or denomination.
4. Supporting Document **ED** must be completed by a college/university school official and school seal must be affixed.
5. Supporting Document **VE** must be completed if application is made on the basis of three year diploma nurse or Associate Degree and experience.
6. Fee payment schedule is indicated on the **REFERENCE SHEET**.
7. Since the application for examination is a dual process, you must do the following:

   A. NAB EXAMINATION ONLY

   If you are applying to take NAB examination, complete the Department's green licensure/examination application and submit it along with a certified check or money order to Continental Testing Service, Inc., P.O. Box 100, LaGrange, Illinois 60525-0100 where it will be screened for eligibility. (You may include the additional exam fee to CTS at this time, if you are also applying for the Illinois Supplemental Jurisdictional Examination. See Subparagraph B); ***or***

   **Apply Directly On-Line**. Register for the examination by referring to the Continental Testing Web site (**www.continentaltesting.net**) for information on how to apply for the examination on-line and pay the test fee by credit card.

   **At the same time**, register for the NAB examination online via the link from the NAB home page (www.nabweb.org) or www.proexam.org/NAB. Information for Candidate Handbooks in electronic form are also assessible on the NAB website.

   Once you have completed both processes and are determined eligible you will receive an Authorization to Test (ATT) that will contain the necessary information to schedule yourself for NAB examination. The ATT eligibility lasts for 60 days only. You must take the examination within those 60 days or reapply with a new fee.

   B. ILLINOIS SUPPLEMENTAL JURISDICTIONAL EXAMINATION ONLY

   If you are applying to take **ONLY** the Illinois Supplemental Jurisdictional Examination, complete the Department's green licensure/examination application and submit it along with a certified check or money order to Continental Testing Service, Inc., P.O. Box 100, LaGrange, Illinois 60525-0100 where it will be screened for eligibility.

Review the Reference Sheet for the final filing dates, examination dates and examination fees.

# ENDORSEMENT OF LICENSE

***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.***

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

2. Supporting Document **CT** must be completed by the U.S. jurisdiction of original licensure and the U.S. jurisdiction of current licensure where you have most recently practiced. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to you;

3. A copy of Act and Rules from original state of licensure during year license was received;

4. Supporting Document **HL** must be completed by your examining physician and the examination must have occurred within one (1) year preceding your application. Those individuals applying for licensure pursuant to certification by a recognized church or religious denomination which teaches reliance on spiritual means alone for healing, must submit verification of membership with a recognized church or religious denomination which teaches reliance on spiritual means alone for healing. An applicant applying under this provision will be issued a Limited Nursing Home Administrator License which will allow the individual to be an administrator in an institution of the certifying church or denomination.

5. Supporting Document **VE** must be completed by your employer and returned with your application package.

6. If applying on the basis of education and experience, Supporting Document **SD-HLT** must be completed by an official of the Department of Health in the state where you were employed as a nursing home administrator.

7. Submit official transcripts with school seal affixed showing graduation from an accredited college or university; or three year diploma nurse program; or an associate degree or its equivalent; or certification of successful completion of the Professional Certification Program.

8. Fee payment must be in the form of a check or money order and made payable to the Department of Financial and Professional Regulation.

9. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

NOTE: Your application and supporting documents may be reviewed by the Nursing Home Administrators Licensing and Disciplinary Board of the Department of Financial and Professional Regulation. Upon approval of your endorsement application, you will be required to take the Illinois Supplemental Examination.

# RESTORATION

***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.***

**~IMPORTANT NOTICE~**

These Restoration Instructions apply only to those nursing home administrators whose licenses have been on inactive status, or in non-renewed status, for five or more years.

**If your license has been inactive, or in non-renewed status, for less than five years, you should contact the Department of Financial and Professional Regulation at 1-800-560-6420 for detailed instructions on how to restore it to active status.**

If you are restoring an inactive license after five (5) years, you must file an application together with proof of 36 hours of continuing education or three (3) semester hours of completed college level course work and either submit:

a. sworn evidence certifying to active practice in another state; OR
b. an affidavit attesting to military service; OR
c. proof of an additional 36 hours of continuing education completed within 2 years prior to restoration application; OR
d. successfully complete both portions of the examination (IL Supplemental and the NAB).

If you are restoring after active military service but within 2 years of termination of military service, you shall submit a DD214.

In addition to the above, applicants must submit:

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document **CT** to verify proof of licensure as a nursing home administrator in another jurisdiction. You must direct the licensing agency/board to return completed form **CT** directly to the address indicated in number 6 below.

   If you have not maintained an active practice in another state/territory, the Nursing Home Administrators Licensing and Disciplinary Board shall, by evaluation, determine your fitness to resume active practice. The Department may ask you to submit additional documentation after reviewing the initial request for restoration. You may also be required to successfully complete the N.A.B. and Illinois Supplemental Examinations. You may be required to appear before the Board, for an oral interview designed to determine current competency to practice as a nursing home administrator.
3. Supporting Document **RS** must be completed. If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 217-782-0458.
4. Supporting Document **VE** must be completed to verify active practice for 3 years of the last 5 years as a nursing home administrator.
5. Supporting Document **HL** must be completed by your examining physician and the examination must have occurred within one (1) year preceding your application. Those individuals applying for restoration pursuant to certification by a recognized church or religious denomination which teaches reliance on spiritual means alone for healing, must submit verification of membership with a recognized church or religious denomination which teaches reliance on spiritual means alone for healing.
6. Fee payment is indicated in the Official Use Only Box on Supporting Document **RS.** Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.
7. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

# LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

| Licensure Methods | Definition |
|---|---|
| Examination | Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department. |
| Endorsement of License | Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued. |
| Acceptance of Examination | Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state. |
| Restoration | Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review. |
| Grandfather/Waiver | Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only). |
| Non-examination | Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals. |

# 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."**

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"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."**

# REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change examination dates, filing deadlines, and fees if prevailing circumstances necessitate such action.

## CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD & FEE

| PROFESSION NAME | PROFESSION CODE | LICENSURE METHOD | APPLICATION FEE |
|---|---|---|---|
| Temporary Certificate | 045 | Nonexamination | $ 75.00 |
| Nursing Home Administrator | 044 | Examination | See Chart II Below |
| Nursing Home Administrator | 044 | Endorsement of License | $150.00 |
| Nursing Home Administrator | 044 | Restoration | See Supporting Document **RS** |

## CHART IIA - NAB EXAMINATION CODES AND FEES

| NAB EXAMINATION ONLY | TEST CODES | APPLICATION FEES |
|---|---|---|
| CTS | 01 | $ 98.00 |

Since the application for examination is a dual process, you must do the following:

- ☐ Complete the Department's licensure/examination application by applying online at **www.continentaltesting.net**, where it will be screened for eligibility, and pay the required administration fee with a credit card (VISA or Mastercard). (You may include the additional exam fee to CTS if you are also applying for the Illinois Supplemental Jurisdictional Examination at this time.)
- ☐ AT THE SAME TIME, register for the NAB examination online via the link from the NAB home page (**www.nabweb.org**) or **www.proexam.org/NAB** and pay the required examination fee.

  Once you have completed both processes and are determined eligible you will receive an Authorization to Test (ATT) that will contain the necessary information to schedule yourself for the NAB examination. The ATT eligibility lasts for 60 days only. You must take the examination within those 60 days or reapply with a new fee.
- ☐ Information for Candidate Handbooks in electronic form are accessible on the NAB website at **www.nabweb.org**.

## CHART IIB - ILLINOIS SUPPLEMENTAL JURISDICTIONAL EXAMINATION CODES AND FEES

| SUPPLEMENTAL EXAMINATION | TEST CODES | APPLICATION FEE |
|---|---|---|
| Illinois Supplemental Jurisdictional Examination | 02 | $180.00 |

- ☐ If you are applying to take **ONLY** the Illinois Supplemental Jurisdictional Examination, complete the Department's licensure/examination application by applying online at **www.continentaltesting.net** and pay the required administration fee with a credit card (VISA or Mastercard). See Chart III below for the final filing and test dates for this examination.

## CHART III - DATES AND LOCATION FOR THE ILLINOIS SUPPLEMENTAL JURISDICTIONAL EXAMINATION ONLY

For information on **Examination Dates, Application Deadlines,** and **Test Center Codes** please visit CTS at www.continentaltesting.net.

***APPLICATION FILING DEADLINES WILL BE STRICTLY ENFORCED.***

***NOTE**: Approximately two weeks prior to the examination you will be mailed an admission notice, along with other necessary instructions. If you have not received an admission notice ten days prior to the examination, make inquiry to Continental Testing Services: 708/354-9911.

**SEE PAGE 2 FOR CHART IV - SCHOOL CODES AND FOR ASSISTANCE INFORMATION**

## CHART IV - SCHOOL CODES

**NOT APPLICABLE**

**ENTER N/A IN PART VII c) OF**

**APPLICATION FOR LICENSURE AND/OR EXAMINATION**

## * * * * * REQUEST FOR ASSISTANCE * * * * *

If assistance is needed, direct your request (based upon your licensure method)
to one of the following telephone numbers:

| Licensure Methods **Except** Examination **(US ONLY)** | Examination Licensure Method **Only** |
|---|---|
| 1-800-560-6420<br>TTY<br>1-866-325-4949<br>Please allow 6 weeks from mailing your application before making an inquiry concerning its status. | 1-708-354-9911 |

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Licensed Nursing Home Administrator

***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.***

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

| FOUR-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. | Examination Coding Information (if applicable) | |
| Part VIII. | Child Support and/or Tax Information | |
| Part IX. | Certifying Statement--Signed and Dated | |

| SUPPORTING DOCUMENTS | SUBMITTED |
|---|---|
| Application Fee | |
| Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form. | |
| **ED** Form with school seal affixed | |
| **HL** Form completed and signed by licensed physician | |
| **CA-NHA** Form (for temporary nursing home administrator license) | |
| **VE** Form (submit if not applying with a baccalaureate degree or higher) | |
| **SD-HLT** Form (submit if using education and experience for endorsement) | |
| Act & Rules (from the original state of licensure for endorsement) | |
| Certificate from the Professional Certification Program for Nursing Home Administrators (fulfills education/experience requirement for endorsement) | |
| **CT** Form (original state of licensure) | |
| **RS** Form (restoration method only) | |
| Copy of **DD214** (if restoring from active military service) | |
| Proof of Name Change (if applicable) | |

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

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# APPLICATION FOR LICENSURE AND/OR EXAMINATION

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.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. 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.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

A. Type or print legibly with black ink only.

B. **FEES ARE 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.

## PART I: Application Category Information

A. **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.

B. SEE **REFERENCE SHEET, CHART I, OR INSTRUCTIONS** PRIOR TO COMPLETING ITEMS 1 THROUGH 4

| 1. PROFESSION NAME | 2. PROFESSION CODE | 3. LICENSURE METHOD | 4. FEE |
|---|---|---|---|
| | ___ ___ ___ | | $ |

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for this profession in Illinois.

☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

☐ Other: _____

☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

## PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

| 1. NAME LAST FIRST MIDDLE | 2. TITLE (e.g., M.D., D.D.S., etc.) | 3. UNITED STATES SOCIAL SECURITY NO. |
|---|---|---|
| | | __ __ __ - __ __ - __ __ __ __ |

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

__ __ __ __ __ - __ __ __ __

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

__ __ __ __ __ - __ __ __ __

| 6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE) | 7. MOTHER'S MAIDEN NAME |
|---|---|
| | |

| 8. PLACE OF BIRTH CITY STATE/COUNTRY | 9. DATE OF BIRTH | 10. AGE |
|---|---|---|
| | __ __ / __ __ / __ __ __ __<br>Month Day Year | ____ ☐ Female ☐ Male |

| 11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED | 12. **REQUIRED** E-MAIL ADDRESS |
|---|---|
| Work: ( __ __ __ ) __ __ __ -- __ __ __ __ (Area Code)<br>Home: ( __ __ __ ) __ __ __ - __ __ __ __ (Area Code)<br>Fax: ( __ __ __ ) __ __ __ - __ __ __ __ (Area Code)<br>Fax: ( __ __ __ ) __ __ __ -- __ __ __ __ (Area Code) | |



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

## PART III: Education Information

1. PRELIMINARY EDUCATION (Elementary and High School or G.E.D. Circle number of years completed)

**1 2 3 4 5 6 7 8 9 10 11 12** Graduated High School? ☐ Yes ☐ No OR Received G.E.D.? ☐ Yes ☐ No

| 2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED | 3. LAST PRELIMINARY SCHOOL LOCATION (City and State) | 4. DATE OF GRADUATION ___ ___ / ___ ___ ___ ___ Month Year |
|---|---|---|
| | | |

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

**1 2 3 4 5 6 7 8** Graduated? ☐ Yes ☐ No

| 6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate) | LOCATION (City and State or Country) | DATES OF ATTENDANCE | | TYPE OF DEGREE EARNED |
|---|---|---|---|---|
| | | FROM | TO | |
| | | Month/Year | Month/Year | |
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

7. SPECIALIZED TRAINING (Residency, Professional Training, Vocational Training, Practical or Clinical Training)

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

NAME (Last, First, MI):

SS#:

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, the INSTRUCTION SHEET enclosed with this Application package may instruct you 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 (Active, Lapsed, etc.) |
|---|---|---|---|---|
| State of Original Licensure | | | | |
| State of Current Licensure where you most recently have been practicing. | | | | |
| Other States of Licensure | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

***(If additional space is needed, attach a separate sheet.)***

## PART V: Record of Examination

*If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.*

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

***(If additional space is needed, attach a separate sheet.)***

NAME (Last, First, MI):

SS#:

Profession:

| PART VI: Personal History Information *(This part must be completed by all applicants)* | YES | NO |
|---|---|---|
| 1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.* | | |
| 2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.* | | |
| 3. 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 VII: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes

b) CHART III - Select the examination site you desire and enter Test Center Code:

c) CHART IV - Find your School of Graduation and enter school code:

d) Record the number of times you have taken this exam in Illinois or any other state:

## PART VIII: 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 ☐

## PART IX: 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.

NAME (Last, First, MI):

SS#:

Profession:

**IMPORTANT NOTICE:** Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

# CCA

| 1. NAME LAST FIRST MIDDLE | 3. PROFESSIONAL LICENSE NUMBER (if any) ___ - _____ |
|---|---|
| 2. ADDRESS STREET, CITY, STATE, ZIP CODE | 4. SOCIAL SECURITY NUMBER ___ - __ - ____ |

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

- ☐ Acupuncturists
- ☐ Advanced Practice Registered Nurses
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ Athletic Trainers
- ☐ Audiologists
- ☐ Clinical Psychologists
- ☐ Clinical Social Workers
- ☐ Dental Hygienists
- ☐ Dentists
- ☐ Genetic Counselors
- ☐ Licensed Clinical Professional Counselors
- ☐ Licensed Practical Nurses
- ☐ Licensed Social Workers
- ☐ Marriage and Family Therapists
- ☐ Medication Aide
- ☐ Naprapaths
- ☐ Nursing Home Administrators
- ☐ Occupational Therapists
- ☐ Occupational Therapy Assistants
- ☐ Optometrists
- ☐ Orthotists
- ☐ Pedorthists
- ☐ Perfusionists
- ☐ Pharmacists
- ☐ Physical Therapists
- ☐ Physical Therapy Assistants
- ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
- ☐ Physician Assistants
- ☐ Podiatrists
- ☐ Professional Counselors
- ☐ Prosthetists
- ☐ Registered Nurses
- ☐ Registered Surgical Assistants
- ☐ Registered Surgical Technologists
- ☐ Respiratory Care Practitioners
- ☐ Speech Pathologists

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 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.*

## 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.

**This page intentionally left blank for double-sided printing.**

| IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. | **CERTIFICATION OF EDUCATION** | SUPPORTING DOCUMENT **ED** |
|---|---|---|

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

| | | |
|---|---|---|
| 1. NAME LAST FIRST MIDDLE | 2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year | 3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __ |
| 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. | |
| 6. MAIDEN OR GIVEN SURNAME | Profession Name | Profession Code |
| 7. NAME OF INSTITUTION ATTENDED | 8. DATE OF GRADUATION / COMPLETION __ __ / __ __ / __ __ __ __ Month Day Year | |

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

Date _____ Signature of Applicant _____

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

| | |
|---|---|
| A. NAME OF INSTITUTION | B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE |
| C. DEPARTMENT OF INSTITUTION | D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT |
| E. MAJOR AREA OF STUDY OF THE APPLICANT | F. APPLICANT WAS (CHECK ONE): ☐ Full-time ☐ Part-time ☐ Co-op |
| G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) ☐ _____ Semester Hours ☐ _____ Quarter Hours ☐ _____ Course Hours | H. DATES OF ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year |
| I. Total academic years attended _____ Years _____ Months _____ Days **OR** Total calendar years attended _____ Years _____ Months _____ Days | J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.) |
| K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET __ __ / __ __ / __ __ __ __ Month Day Year | L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED __ __ / __ __ / __ __ __ __ Month Day Year |

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

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

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

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

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

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

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

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

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

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

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

Date of Expiration

Signature of Notary Public

**SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT**

**ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.**

**NAME (Last, First, MI):**

**SS#:**

**Profession:**

| IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. | **VERIFICATION OF EMPLOYMENT / EXPERIENCE** | SUPPORTING DOCUMENT **VE** |
|---|---|---|

**APPLICANT:** ***Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. You are authorized to photocopy this form as necessary.***

| | | |
|---|---|---|
| 1. NAME LAST FIRST MIDDLE | 2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year | 3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __ |
| 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. JOB TITLE OR POSITION APPLICANT HELD | |
| 8. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ Month Day Year To __ __ /__ __ /__ __ __ __ Month Day Year | 9. SUPERVISOR NAME | |

**EMPLOYER:** ***Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.***

**PART I** - EMPLOYMENT INFORMATION

| | | |
|---|---|---|
| A. EMPLOYER NAME | | B. BUSINESS / INSTITUTION NAME |
| C. EMPLOYER REGISTRATION/LICENSE NUMBER | D. STATE OF EMPLOYER REGISTRATION/LICENSE | E. BUSINESS ADDRESS STREET CITY STATE ZIP CODE |
| F. BUSINESS REGISTRATION/LICENSE NUMBER (If Applicable) | G. STATE OF BUSINESS REGISTRATION/LICENSE | H. BUSINESS TELEPHONE NUMBER Area Code (___ ___ ___) ___ ___ ___-___ ___ ___ ___ |

**PART II** - APPLICANT EMPLOYMENT INFORMATION

| | | |
|---|---|---|
| A. NUMBER OF HOURS WORKED PER WEEK | B. TYPE OF EMPLOYMENT [ ]Full-time [ ]Part-time | C. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ Month Day Year To __ __ /__ __ /__ __ __ __ Month Day Year |
| D. RECORD APPLICANT'S POSITION TITLE(S) | | |
| E. GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT. | | |

I do hereby declare that this information is true and correct.

_____ Signature

_____ Date

_____ Title

| IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 70/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. | **CERTIFICATION OF ACCEPTANCE** | SUPPORTING DOCUMENT **CA-NHA** |
|---|---|---|

**APPLICANT:** ***To ensure timely receipt of a temporary license, the completed application packet for licensure must be received in the Department of Financial and Professional Regulation at least 60 days prior to the appointment of the individual as a nursing home administrator.***

| 1. NAME LAST FIRST MIDDLE | 2. DATE OF BIRTH<br>__ __ / __ __ / __ __ __ __<br>Month Day Year | 3. SOCIAL SECURITY NUMBER<br>__ __ __ - __ __ - __ __ __ __ |
|---|---|---|
| 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.<br>_____ ___ ___ ___<br>Profession Name Profession Code | |
| 6. MAIDEN OR GIVEN SURNAME | _____ ___ ___ ___<br>Profession Name Profession Code | |

**EMPLOYER:** ***This is to certify that the above-named applicant has been appointed as a full-time nursing home administrator in the facility as follows:***

**PART I.** - EMPLOYER INFORMATION

| A. EMPLOYER NAME | B. BUSINESS/INSTITUTION NAME |
|---|---|
| C. EMPLOYER LICENSE NUMBER (If applicable) | D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE |
| E. BUSINESS/INSTITUTION LICENSE NUMBER (If applicable) | F. BUSINESS TELEPHONE NUMBER<br>Area Code ( __ __ __ ) __ __ __ — __ __ __ __ |

**PART II.** - APPLICANT EMPLOYMENT INFORMATION

| A. TYPE OF EMPLOYMENT<br>☐ Part-time ☐ Full-time | B. HOURS PER WEEK |
|---|---|
| C. DATE APPLICANT ACCEPTED OR APPOINTED AS NURSING HOME ADMINISTRATOR<br>__ __ / __ __ / __ __ __ __<br>Month Day Year | D. BEGINNING DATE OF EMPLOYMENT AS ADMINISTRATOR<br>__ __ / __ __ / __ __ __ __<br>Month Day Year |

I do hereby declare that the above-named applicant has been/will be employed as indicated.

_____
Employer Signature

_____
Title

_____
Date

| IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed. | **CERTIFICATE OF HEALTH** | SUPPORTING DOCUMENT **HL** |
|---|---|---|

**APPLICANT: Complete the applicant section of this form. The physician who examines you MUST hold an active license in the jurisdiction in which he/she practices. Direct the physician to complete the Examining Physician Section of this form and return the completed form to you for inclusion with your Application for Licensure and/or Examination.**

| 1. NAME LAST FIRST MIDDLE | 2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year | 3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __ |
|---|---|---|
| 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. | |
| 6. MAIDEN OR GIVEN SURNAME | _____ Profession Name | __ __ __ Profession Code |

**EXAMINING PHYSICIAN: Complete the remainder of this form. Reference the above profession name to determine the appropriate statement to check-off. Return the completed form to the applicant. Physical examination must have occurred within the preceeding 12 months.**

| A. PHYSICIAN NAME FIRST MIDDLE LAST | B. PHYSICIAN LICENSE NUMBER |
|---|---|
| C. STREET ADDRESS | D. STATE OR TERRITORY OF LICENSURE |
| E. CITY, STATE, ZIP CODE | F. DATES OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION |

STATEMENT I: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

## NURSING HOME ADMINISTRATOR

The above-named applicant is of sound physical and mental health. ☐ Yes ☐ No

STATEMENT II: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

## FUNERAL DIRECTOR AND EMBALMER

The above-named applicant received the following:
1)Diptheria-Tetanus (adult type) immunizations ☐ Series ☐ Booster
2)Hepatitis B ☐ Series

I hereby declare that the above information is true and correct.

_____ Signature

_____ Date