

INSTRUCTION SHEET

Medical--Visiting Resident Permit

***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 and then follow all directions. This will aid you in accurately completing your application and thus, eliminate any delay in processing. If approved, a visiting resident permit shall be valid for 180 days or until such time as the clinical studies or techniques are completed, whichever occurs first.

Only one Visiting Resident Permit shall be issued to an applicant for the same period of time. The applicant may be required to appear before the Medical Licensing Board for an interview prior to, and as a requirement for, the issuance of a temporary visiting resident permit.

Application for Licensure and/or Examination

Complete the four-page Application for Licensure and/or Examination as follows:

1. Part I-A--Application Category Information--Complete Part I-A as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Visiting Resident Permit	188	Non-Examination	\$100

2. Part I-B--Check the box indicating the appropriate information regarding your application.
3. Part II--Applicant Identifying Information--Enter all applicable information requested. On number 3, Social Security Number is mandatory.
4. Part III--Education Information
 - a. Numbers 1 through 5--Enter all applicable information requested.
 - b. Number 6--Indicate all postsecondary education since graduation from high school. Please indicate beginning and ending dates by month and year.
5. Part IV--Record of Licensure Information--Indicate any license, registration, permit or authorization held to practice in the medical profession in the United States, Canada, foreign country, territory or province.

~For Assistance~

*Call the Department of
Financial and
Professional Regulation
at one of the following
numbers and state that
you are applying for a
Permit as a Visiting
Resident and need help
with your application:*

217-782-8556

TDD - 217-524-6735

*You may obtain copies of
the Medical Practice Act
and Rules by calling:*

217-782-0458

6. Part V--Record of Examination--Must be completed by all applicants. List all examinations taken; i.e., state constructed, FLEX, USMLE and National Boards.
7. Part VI--Personal History Instructions--Must be completed by all applicants. If any of your responses to questions 1 through 4 is "yes," submit a detailed statement explaining your affirmative response and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

Question 1--A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s), if probation given, verification that probation was completed satisfactorily, a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

Submit a statement for each conviction indicating date and place of conviction, nature of offense, and if applicable, the date of discharge from any penalty imposed.

Question 2--A report from any and all physicians, counselors, or therapists from whom you have received treatment for this disease, impairment, or condition. The report must include dates of treatment, method of treatment, diagnosis, and prognosis.

Submit a copy of each of your treating physician's curriculum vitae and verification of board certification if board certified in a Specialty.

If you have been treated as an inpatient at any time for this disease, impairment, or condition, then it will be necessary for you to have the institution(s) submit copies of exact dates of treatment, any and all admitting histories and physicals and discharge summaries for each inpatient stay, directly to this Department.

Question 3--A detailed explanation is required if you have been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way in Illinois or elsewhere. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 4--If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to the Department, any and all information relative to your discharge.

8. Part VII--Examination Coding Information--Not applicable.
9. Part VIII--Child Support and Student Loan Information--Must be completed by all applicants.
10. Part IX--Certifying Statement--Read the certifying statement and then sign and date your application.

INITIAL PERMIT

You must submit the following with the properly completed 4-page Application for Licensure and/or Examination:

1. **VRP** (Certification of Acceptance and Enrollment for a Visiting Resident Permit) form must be completed by the Illinois patient care clinic or facility indicating beginning and ending dates of training not to exceed 180 days. Form must bear the clinic/facility seal or be notarized. Form must be completed by the approved program located in another state verifying enrollment and dates of training. Form must bear the official seal of the hospital/institution or be notarized.
2. **CT** (Certification of Licensure) from the jurisdiction of current licensure indicating the date of issuance and current status of license.
3. The \$100 fee made payable to the Department of Financial and Professional Regulation.

MAILING ADDRESS

Submit the required documents not less than 60 days before the commencement date of the training to:

Department of Financial and Professional Regulation
Attn: Division of Professional Regulation
320 West Washington Street, 3rd Floor
Springfield, IL 62786

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.**"

"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 Visiting Resident Permit

*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 Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
CT (Certification of Licensure) Form from jurisdiction of current licensure	
VRP Form	

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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. 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 \$
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B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|---|--|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> 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 ____ / ____ / ____ Month Day Year	10. AGE ____ <input type="checkbox"/> Female <input type="checkbox"/> Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) _____ - _____ Home: (____) _____ - _____ (Area Code) (Area Code) Fax: (____) _____ - _____ Fax: (____) _____ - _____ (Area Code) (Area Code)		12. PREFERRED e-MAIL ADDRESS(ES) [If available]

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.)

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

**CERTIFICATION OF ACCEPTANCE
AND ENROLLMENT FOR A
VISITING RESIDENT PERMIT**

SUPPORTING DOCUMENT

VRP

1 8 8
Profession Code

NOTE: *An applicant shall not commence limited specialty/residency training before the program receives written notification from the Department of Financial and Professional Regulation.*

APPLICANT: *Complete Sections 1-3 of this form and forward it to the hospital/institution where you are currently enrolled in residency training.*

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month Day Year	3. SOCIAL SECURITY NUMBER ____ - ____ - ____
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OUT-OF-STATE PROGRAM DIRECTOR: *Complete Parts A-G, sign, affix official seal and return to the applicant.*

A. HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE ____ / ____ / ____ Month Day Year	C. ENDING DATE ____ / ____ / ____ Month Day Year
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	E. SPECIALTY/RESIDENCY NAME	
F. BUSINESS TELEPHONE NUMBER Area Code (____) _____ - _____	G. CHECK THE BOX BELOW IF THE PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY. <input type="checkbox"/> THE RESIDENCY PROGRAM IS AFFILIATED WITH THE ILLINOIS FACILITY.	

I do hereby declare that the above-named applicant is a resident in good standing in the above ACGME/AOA accredited training program.

S E A L

Signature of Program Director

Print Name of Program Director

Date

ILLINOIS PROGRAM: *Complete the remainder of this form, sign, affix official seal or notary seal and submit with the application for the above-named applicant.*

A. PATIENT CARE CLINIC OR FACILITY NAME	B. BEGINNING DATE ____ / ____ / ____ Month Day Year	C. ENDING DATE ____ / ____ / ____ Month Day Year
D. BUSINESS ADDRESS (STREET, CITY, STATE, ZIP CODE)	E. SPECIALTY/RESIDENCY NAME	F. YEAR OF POSTGRADUATE TRAINING
G. BUSINESS TELEPHONE NUMBER Area Code (____) _____ - _____	H. BUSINESS FAX NUMBER Area Code (____) _____ - _____	

I do hereby declare that the above-named applicant has been accepted for limited specialty/residency training in Illinois as indicated above for a period not to exceed six (6) months. I further hereby declare that I assume full supervisory responsibility for the individual during the period specified.

CLINIC, FACILITY,
OR NOTARY
S E A L

Signature of Illinois Supervising Physician

036 -
Type or Print Name of Illinois Supervising Physician and IL License #

Date

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

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. 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. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (_____) _____	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

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

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

A. The applicant has written is scheduled to write the following examination:
Name of Examination _____ Date of Examination _____

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF 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	
<input type="checkbox"/> Examination (Administered in Your State) <ul style="list-style-type: none"> <input type="checkbox"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> Endorsement of License (State) _____ Acceptance of Examination Results _____ (Administered in Another State) <ul style="list-style-type: none"> <input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather <input type="checkbox"/> Credentials <input type="checkbox"/> Other (Describe) _____ 	

F. CURRENT LICENSURE STATUS	G. IF LICENSED BY EXAMINATION, RECORD SCORES												
<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	<table border="0"> <tr> <td>Type of Examination</td> <td>Score</td> </tr> <tr> <td>Written</td> <td>_____</td> </tr> <tr> <td>Practical</td> <td>_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td></td> </tr> <tr> <td>Received no Grade Below</td> <td>_____</td> </tr> <tr> <td>Examination Period _____ days _____ hours</td> <td></td> </tr> </table>	Type of Examination	Score	Written	_____	Practical	_____	Other (Describe) _____		Received no Grade Below	_____	Examination Period _____ days _____ hours	
Type of Examination	Score												
Written	_____												
Practical	_____												
Other (Describe) _____													
Received no Grade Below	_____												
Examination Period _____ days _____ hours													

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2.

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- 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 - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

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

S E A L	_____	_____
	Print Name	Signature
	_____	_____
	Title	Date
	_____	_____
	Agency/Board Street Address	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.

NAME (Last, First, MI):

SS#:

Profession: