IMPORTANT NOTICE: Completion of this form is necessary for consideration under 225 ILCS 15/1 et. seq. (Illinois Compiled Statues). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	RETURN APPLICATION TO: STATE OF ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION DIVISION OF PROFESSIONAL REGULATION 320 West Washington Street, 3rd Floor Springfield, Illinois 62786	FOR OFFICIAL USE ONLY _____ License Number Issued _____ Date License Issued

APPLICATION FOR LICENSURE AS AN ASSOCIATION OR PARTNERSHIP UNDER THE CLINICAL PSYCHOLOGIST LICENSING ACT

INSTRUCTIONS

1. The required fee of $50, made payable to the Department of Financial and Professional Regulation, must accompany this application. **This fee is not refundable**.

2. In accordance with Section 15/3 of the Clinical Psychologist Licensing Act, every member, partner, and employee who renders clinical psychological services of the below-indicated firm shall at all times hold a currently valid license as a clinical psychologist.

   Practicum students, interns, or post-doctoral candidates seeking to fulfill educational or professional requirements in order to qualify for a license, may assist in the rendering of services, provided that such employees function under the direct supervision, order, control, and full professional responsibility of a licensed clinical psychologist in the partnership or association and are not held out to the public as clinical psychologists or psychologists. *List any such person on the reverse side of this form.*

3. If applicable, attach a copy of the Secretary of State's letter of authority as Limited Partnership.

1. NAME OF FIRM	2. TYPE OF LICENSURE ☐ Association ☐ Partnership ☐ Limited Partnership	3. DATE FIRM WAS FORMED

4. ADDRESS OF PRINCIPAL OFFICE (Street Address, City, State ZIP Code)

5. NAMES OF MEMBER(S), PARTNER(S), AND EMPLOYEE(S) WHO PRACTICE CLINICAL PSYCHOLOGY OR RENDERS CLINICAL PSYCHOLOGICAL SERVICES - Use reverse side of form if more space is needed.)

NAME	ADDRESS (Street, City, State, ZIP Code)	ILLINOIS CLINICAL PSYCHOLOGIST LICENSE NO.

STATE OF _____)

COUNTY OF _____)

I hereby certify that I personally completed this application, that the answers appearing hereon are true and correct to the best of my knowledge and belief, and that I am legally authorized to sign for this firm.

NOTARY
S E A L

_____
Signature of Applicant

Subscribed and sworn before me this _____ day of _____, _____

_____
Signature of Notary Public

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.

PRINT RESET