INSTRUCTION / INFORMATION SHEET

ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY (Profession Code - 277)

- Certified Nurse Midwife
- Certified Clinical Nurse Specialist
- Certified Nurse Practitioner

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: A CURRENT ILLINOIS REGISTERED NURSE LICENSE AND A CURRENT ILLINOIS ADVANCED PRACTICE REGISTERED NURSE LICENSE ARE REQUIRED FOR FULL PRACTICE AUTHORITY.

Before completing the application package, please read the following.

APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE FULL PRACTICE AUTHORITY LICENSURE

- Part I, Box 5, page 1 - Specify the category of advanced practice nursing for which your are applying. A separate fee and application is required for each category.
- Part I, Box 6, page 1 - Indicate your current Illinois Registered Nurse License Number and Illinois APRN License Number.
- Part II-VIII, pages 1 and 2 - Complete all applicable information requested in pages 1 and 2.

APRN-FPA LICENSURE REQUIREMENTS

- Specific instructions for each category of advanced practice registered nursing for which you are applying are located on the following pages.
- Locate the instructions for specific category you selected in Part 1, Box 5 of the Application for Advanced Practice Nurse Licensure and follow those instructions only.

ASSISTANCE IN COMPLETING APPLICATIONS

- If you need assistance in completing the application, you may call 1-800-560-6420 or (TTY) 1-866-325-4949. Inform the operator that you are applying for Advanced Practice Registered Nurse - Full Practice Authority Licensure and that you would like assistance in completing your application.

APPLICATION FEE

- The APRN-FPA application fee is $125. A separate fee and application are required for each category of licensure. The fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation. THIS FEE IS NOT REFUNDABLE.

SUBMISSION OF APPLICATION

- The two-page application, supporting documents and fee payment should be forwarded as a complete packet to:
  
  Illinois Department of Financial and Professional Regulation
  ATTN: Division of Professional Regulation
  P.O. Box 7007
  Springfield, Illinois 62791

APPLICATION LICENSURE EXPIRATION

- The application, which you submit, is valid for three (3) years from the date of receipt.
- All Illinois Advanced Practice Registered Nurse - Full Practice Authority licenses will expire on May 31 of every even-numbered year.

NOTES:

- Upon issuance of an APRN license with Full Practice Authority, the regular APRN license will go inactive.
- Prior to prescribing as an APRN granted Full Practice Authority, the APRN must apply for a practitioner license under the Illinois Controlled Substances Act.

The Illinois Nurse Practice Act and Rules and additional application forms for Advanced Practice Registered Nurse Licensure and for the Controlled Substance License can be downloaded from the IDFPR Web site at: www.idfpr.com
CERTIFIED NURSE PRACTITIONER

Submit the following documents and/or forms with the two-page application and fee:

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

2. A current copy of your national certification (certification or pocket card accepted) from one of the following:
   - American Academy of Nurse Practitioners Certification Program as a Nurse Practitioner
   - American Nurses Credentialing Center as a Nurse Practitioner
   - The Pediatric Nurse Certification Board as a Nurse Practitioner
   - The National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties as a Nurse Practitioner
   - The Certification Board for Urologic Nurses and Associates as a Urologic Nurse Practitioner.

3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.

4. Supporting Document VE-APRN-FPA must be completed indicating 4000 hours of clinical experience.

CERTIFIED NURSE MIDWIFE

Submit the following documents and/or forms with the two-page application and fee:

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

2. A current copy of your national certification (certification or pocket card accepted) from one of the following:
   - The American College of Nurse Midwives (ACNM); OR
   - The American College of Nurse Midwives Certification Council (ACC)

3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.

4. Supporting Document VE-APRN-FPA must be completed indicating 4000 hours of clinical experience.
Submit the following documents and/or forms with the two-page application and fee:

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

2. A current copy of your national certification (certification or pocket card accepted) from one of the following:

- American Nurses Credentialing Center (ANCC)
  - Clinical Nurse Specialist
  - Clinical Specialists in Community Health Nursing
  - Clinical Specialists in Gerontology Nursing
  - Clinical Specialists in Home Health Nursing
  - Clinical Specialists in Pediatric Nursing
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adults
  - Clinical Specialists in Psychiatric and Mental Health Nursing - Adolescent
- American Association of Critical Care Nurses as a Clinical Nurse Specialist
- Rehabilitation Nursing Certification Board as a Certified Rehabilitation Registered Nurse--Advanced
- Oncology Nursing Certification Corporation as an Advanced Oncology Certified Nurse (AOCN)
- Certification Board for Urologic Nurses and Associates as a Urologic Clinical Nurse Specialist.
- American College of Cardiovascular Nursing
- American Association of Critical Care Nurses
- American Association of Neuroscience Nurses
- American Board of Occupational Health Nurses, Inc.
- American Holistic Nurses Association
- American Society of Perianesthesia Nurses
- American Society of Plastic Reconstructive Surgical Nurses
- Association of Nurses in AIDS Care
- Board of Certification of Emergency Nurses
- Certification Board of Perioperative Nurses, Inc.
- Certification of Pediatric Oncology Nurses
- Certification Board of Gastroenterology Nurses
- Dermatology Certification Board
- International Board of Lactation Consultants
- International Nurses Society of Addictions
- IV Nurses Certification Corporation
- National Association of School Nurses, Inc.
- National Board of Certification of Hospice and Palliative Nurses
- National Certification Board for Diabetes Educators
- National Certification Board of Pediatric Nurse Practitioners/Nurses
- National Certification Corporation for the Obstetric, Gynecological and Neonatal Nursing Specialties
- National Certifying Board for Ophthalmic Registered Nurses
- Nephrology Nursing Certification Board
- Oncology Nursing Certification Corporation
- Orthopedic Nurses Certification Board
- Rehabilitation Nursing Certification Board
- Vascular Nursing Certification Board
- Wound, Ostomy, and Continence Society

3. Affidavit certifying 250 hours of additional Continuing Education (CE) or training.

4. Supporting Document VE-APRN-FPA must be completed indicating 4000 hours of clinical experience.
SPECIAL INSTRUCTIONS FOR APPLICANTS SEEKING LICENSURE IN MORE THAN ONE ADVANCED PRACTICE NURSING CATEGORY

Applicants seeking licensure in more than one advanced practice nursing category may apply for licenses for multiple advanced practice nurse licensure categories if the applicant has met the requirements for at least one advanced practice nursing specialty; and

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

2. Submits proof in the form of official transcripts with the school seal affixed that he/she possesses an additional graduate education that results in a certificate for another clinical advanced practice nurse category and that meets the requirements for the national certification from the appropriate nursing specialty; and

3. He/she submits a copy of a current, national certification from the appropriate certifying body for that additional advanced practice nursing category.
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."
Before you mail your application, check the following items to make sure your application is complete!

**TWO-PAGE APPLICATION REVIEW**

<table>
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<th>Part I.</th>
<th>Application Category Information</th>
</tr>
</thead>
<tbody>
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<td>Applicant Identifying Information</td>
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<td>Part III.</td>
<td>Personal History Information</td>
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<td>Part IV.</td>
<td>Child Support and/or Taxes</td>
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<td>Part V.</td>
<td>Certifying Statement--Signed and Dated</td>
</tr>
</tbody>
</table>

**SUPPORTING DOCUMENTS**

| 2-page Application for Licensure and/or Examination |
| Application Fee--$125; |

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

**CURRENT COPY OF NATIONAL CERTIFICATION**

- **VE APRN-FPA** form **must** indicate 4000 hours of clinical experience

- **AFFIDAVIT** certifying the completion of 250 additional Continuing Education or Training

All supporting documents **may not be required**. Please refer to application instructions for your specific method of licensure.
APPLICATION FOR ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY LICENSURE

A CURRENT ILLINOIS REGISTERED NURSE LICENSE IS REQUIRED FOR ADVANCED PRACTICE REGISTERED NURSE - FULL PRACTICE AUTHORITY LICENSURE

PART I: Application Category Information

1. PROFESSION NAME
   Advanced Practice Registered Nurse - Full Practice Authority

2. PROFESSION CODE
   277

3. LICENSURE METHOD
   Non-examination

4. FEE
   $125

5. CHECK ONE OF THE FOLLOWING BOXES INDICATING THE CATEGORY OF ADVANCED PRACTICE NURSE:
   ☐ Certified Clinical Nurse Specialist
   ☐ Certified Nurse Practitioner
   ☐ Certified Nurse Midwife

6. INDICATE YOUR CURRENT ILLINOIS REGISTERED NURSE AND APRN LICENSE NUMBERS:
   041-
   209

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE
2. TITLE (e.g., APN Specialty)
3. UNITED STATES SOCIAL SECURITY NO.
4. PERMANENT MAILING ADDRESS
   CITY
   STATE/COUNTRY
   ZIP CODE
   COUNTY

5. MAIDEN, GIVEN, OR OTHER USED NAME(S)

6. PLACE OF BIRTH
   (CITY, STATE/COUNTRY)

7. DATE OF BIRTH
   Month / Day / Year

8. ☐ Female ☐ Male

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
   Work: (___ ___ ___) ___ ___ ___ ___ ___ ___ ___
   Home: (___ ___ ___) ___ ___ ___ ___ ___ ___ ___
   Fax: (___ ___ ___) ___ ___ ___ ___ ___ ___ ___
   E-MAIL ADDRESS (REQUIRED)

PART III: Personal History Information (This part must be completed by all applicants)

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.

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com

IL486-2363 06/19 (APRN-FPA)
PART III: Personal History Information  *(This part must be completed by all applicants)  (CONTINUED)*

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.*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

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.*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

PART IV:  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?  
   (NOTE:  *If you are not subject to a child support order, answer "no."*)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

PART V:  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.
I hereby certify to the following:

* I have completed at least 250 hours of continuing education or training in compliance with Section 1300.465.
* The CE or training in question is the area of certification used to obtain my APRN license.
* I will provide proof of completion to the Department upon request.

<table>
<thead>
<tr>
<th>1. NAME LAST FIRST MIDDLE</th>
<th>2. DATE OF BIRTH</th>
<th>3. SOCIAL SECURITY NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Month / Day / Year</td>
<td>___ - ___ - ___ ___</td>
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</tbody>
</table>

4. ADDRESS STREET, CITY, STATE, ZIP CODE

6. MAIDEN OR GIVEN SURNAME

Signature of Applicant: __________________________ Date: __________________________

Signature of Notary: __________________________ Date: __________________________
I hereby certify to the following:

* I have completed at least 4000 hours of clinical experience after first attaining national certification in accordance with Section 1300.465.
* I will provide proof of completion to the Department upon request.

<table>
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<tr>
<th>1. NAME LAST FIRST MIDDLE</th>
<th>2. DATE OF BIRTH Month / Day / Year</th>
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</table>

4. ADDRESS STREET, CITY, STATE, ZIP CODE

6. MAIDEN OR GIVEN SURNAME

Signature of Applicant ___________________________ Date ___________________________

Signature of Physician or Hospital ___________________________ Date ___________________________
Medical Staff Committee/Designee

Signature of Notary ___________________________ Date ___________________________
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

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)

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
☐ Audiology
☐ 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.)

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:

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),
- 11-9.1 (indecent solicitation 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),
- 11-19.1 (keeping a place of juvenile prostitution),
- 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).

(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 July 1, 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.
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.
If you hold a non-renewed controlled substances registration, you must reinstate that registration. Do not apply for a new registration.

To expedite the processing of your controlled substances application, **SUBMIT THE APPLICATION AND FEE WITH YOUR PROFESSIONAL APPLICATION.**

Every person who prescribes and/or stores and dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.

A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or dispensed.

1. If you do not properly complete Parts I through VII (front and back) of the application, the application will be returned to you and licensure will be delayed.

2. It is **mandatory** that the permanent mailing address and/or business address be a street address. **P.O. boxes are not acceptable. Your Controlled Substances registration must be issued to a street address.**

3. If your professional application is pending, write "pending" in Part IV. A controlled substances registration **will not** be issued until your professional license has been issued. A controlled substances registration **will not** be issued to individuals holding a temporary license.

4. You **must** circle the drug schedules for which you are applying in Part III.

5. You **must** complete and submit the CCA Form. Your application will not be processed without completion of this form.

6. Submit the $5 application fee. Make check or money order payable to the Department of Financial and Professional Regulation (IDFPR). **The fee is non-refundable.** Mail the completed application and fee to:

   Department of Financial and Professional Regulation  
   ATTN: Division of Professional Regulation  
   P.O. Box 7007  
   Springfield, Illinois 62791

A State controlled substances registration is a **prerequisite** for Federal controlled substances registration. The address on your Illinois controlled substances registration must be exactly the same address as your Federal registration. For information concerning Federal registration, you must contact:

   Drug Enforcement Administration  
   230 South Dearborn, Suite 1200  
   Chicago, Illinois 60604  
   Telephone: 312/353-7875  
   Web site: [www.deadiversion.usdoj.gov](http://www.deadiversion.usdoj.gov)

Additional application forms can be downloaded from the IDFPR Web site at [www.idfpr.com](http://www.idfpr.com).
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.

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

PART I: Application Category Information

1. PROFESSION NAME  
   Controlled Substances

2. PROFESSION CODE - Check applicable box
   □ 319 Dentist
   □ 316 Podiatrist
   □ 336 Physician
   □ 346 Optometrist
   □ 390 Veterinarian
   □ 377 APRN-FPA

3. LICENSURE METHOD
   Registration

4. FEE
   $5

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., M.D., O.D., etc.)

3. UNITED STATES SOCIAL SECURITY NO.

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

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

6. EMAIL ADDRESS (REQUIRED)

7. If you will not be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

   I will not be storing or dispensing controlled substances, including samples.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY
   Work ( ) _______________ FAX ( ) _______________
   Home ( ) _______________ FAX ( ) _______________

PART III: Drug Schedule

Circle the schedules for which you are applying:

II  III  IV  V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

Professional License Number

□ Dentist 019 - _______________
□ Optometrist 046 - _______________
□ Physician 036 - _______________
□ Podiatrist 016 - _______________
□ Veterinarian 090 - _______________
□ APN-FP 277 - _______________
### PART V: Personal History Information  
*This part must be completed by all Applicants*

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>YES NO</td>
</tr>
<tr>
<td>2. Have you been convicted of a felony? In general, a felony conviction by itself does not usually result in denial of licensure.</td>
<td>YES NO</td>
</tr>
<tr>
<td>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.</td>
<td>YES NO</td>
</tr>
<tr>
<td>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.</td>
<td>YES NO</td>
</tr>
<tr>
<td>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.</td>
<td>YES NO</td>
</tr>
<tr>
<td>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.</td>
<td>YES NO</td>
</tr>
<tr>
<td>7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.</td>
<td>YES NO</td>
</tr>
</tbody>
</table>

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### PART VI: Child Support 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? (NOTE: If you are not subject to a child support order, answer "no.")

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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### PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

_________________________  
Date of Application

_________________________  
Signature of Applicant

**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.

**Application must be completed in its entirety.  
If not completed, it will be returned to the address noted on front of application.**