

# INSTRUCTIONS

## REGISTERED OCCUPATIONAL THERAPIST CERTIFIED OCCUPATIONAL THERAPY ASSISTANT

### Acceptance of Examination Endorsement of License Restoration

**BEFORE COMPLETING THE APPLICATION PACKET**, read each of the 10 steps below in the order that they are listed, then follow the specific directions as they apply to your method of application. 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.** If you apply for licensure by Acceptance of Examination and are issued a Letter of Authorization to work under the presence of a licensed occupational therapist on site at least 75 percent of your work hours, your Letter of Authorization lasts a maximum of six (6) months and you must cease work immediately if you fail the examination. Only one Letter of Authorization will be issued. If you are issued a license as an Occupational Therapist or as an Occupational Therapy Assistant, please be advised that your license will expire on December 31 of each odd-numbered year.

#### STEPS

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**.
2. Proceed with **Part II** (page one) and complete all applicable information requested. Social Security Number is mandatory.
3. Proceed with **Part III** (page two) and complete all applicable information requested. Indicate Occupational Therapy Education at **Part III**, Number 6.
4. If you have ever been licensed to practice the profession for which you are now making application, or held a related license, proceed with **Part IV** (page three) and complete all applicable information.
5. If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, proceed with **Part V** (page three) and complete all applicable information.
6. Proceed with **Part VI** with your personnel history information. This part must be completed by all applicants.
7. **Part VII** does not apply to Occupational Therapist and/or Occupational Therapy Assistant.
8. **Part VIII** child support and student loan information must be completed by all applicants.
9. **Part IX** must be signed and dated by the applicant.

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

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***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.***

**STEPS (cont'd)**

10. General Information Regarding Examination Requirements for Licensure:
- a. If you are a recent graduate, have met all requirements for examination, and are scheduled for the NBCOT Occupational Therapist/Occupational Therapy Assistant certification examination, you must request the NBCOT to submit proof of passage of examination with a score of 450 or above directly to this Division.
  - b. If you previously took the certification examination for Occupational Therapist/Occupational Therapy Assistant on or after January 1, 1985, you must contact NBCOT and request NBCOT forward your test scores directly to this Division. Notify the NBCOT contact person that a Verification of Certification from NBCOT is **not** acceptable in Illinois for those certified on or after January 1, 1985 and that the examination grade is required.
  - c. If you were certified prior to 1985, Illinois will accept a **Verification of Certification** from NBCOT. This **Verification of Certification** must be forwarded directly from NBCOT to this Department.

NBCOT, Inc.  
ATTN: Verification Letter  
P.O. Box 64971  
Baltimore, MD 21264-4971  
Telephone: 301-990-7979
  - d. 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.

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**ACCEPTANCE OF EXAMINATION**

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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 in its entirety by the Dean or Registrar of the occupational therapy program and it must have school seal affixed.
3. If you have ever been licensed, Supporting Document CT must be completed by the jurisdiction of original licensure and the 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.

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***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.***

**ACCEPTANCE OF  
EXAMINATION  
(cont'd)**

4. Proof of passage of examination must be submitted to this Division directly from the NBCOT.
5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. See **Reference Sheet** (Chart I) for fee payment.
6. 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.

**IMPORTANT INFORMATION REGARDING APPROVAL TO WORK:** If the applicant has been determined eligible for licensure except for passing the examination, the applicant shall be issued a letter of authorization which allows him/her to practice under supervision in accordance with Section 3(6) of the Act. Supervision means the presence of the licensed occupational therapist on site at least 75 percent of the employee's work hours. The applicant shall not begin practice as an occupational therapist or occupational therapy assistant, license pending, until the letter of authorization is received from the Department or until the employer verifies the application is on file with the Department.

If applicant requires a letter of authorization to be issued, verification of acceptance to sit for the NBCOT examination must accompany this application per Section 1315.110 (a)(4) and (b)(4) of the Rules for the Administration of the Occupational Therapy Act.

## ENDORSEMENT OF LICENSE

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 in its entirety by the Dean or Registrar of the occupational therapy program and it must have school seal affixed.
3. Supporting document **CT** must be completed by the jurisdiction of original licensure and the 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.
4. Proof of passage of examination must be submitted to this Division directly from the NBCOT.
5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. See **Reference Sheet** (Chart I) for fee payment.
6. 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.

## 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 registered occupational therapists and or certified occupational therapy assistants 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 Call Center at 1-800-560-6420 for detailed instructions on how to restore it to active status.**

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 **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 Call Center at 1-800-560-6420.
3. Proof of completion of 24 hours of approved continuing education within 24 months prior to the restoration application.
4. **SUBMIT ONE OF THE FOLLOWING:**
  - a. **VE (Verification of Employment/Experience)**--This form must be completed to provide documentation of active practice in another jurisdiction. In addition, a **CT (Certification of Licensure)** form must be submitted by said jurisdiction (board or licensing authority) indicating you were authorized to practice during the term of said active practice;  
OR
  - b. An affidavit attesting to military service or a copy of your DD214 if restoring after active military service;  
OR
  - c. Verification of successful completion of the Certification Examination of the NBCOT for licensure as a registered occupational therapist or certified occupational therapy assistant within the last 5 years prior to applying for restoration;  
OR
  - d. Evidence of successful completion of 48 hours of continuing educational programs in occupational therapy, including attendance at college level courses, professionally oriented continuing education classes, special seminars, or any other similar program within 2 years prior to application for restoration (these hours will be in addition to the 24 hours stated above), or evidence of recent related work experience to show that the applicant has maintained competence in his/her field.
5. Fee payment amount 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.
6. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, Division of Professional Regulation, P.O. Box 7007, Springfield, IL 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 fees if prevailing circumstances necessitate such action.

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

<u>PROFESSION NAME</u>	<u>PROFESSION CODE</u>	<u>LICENSURE METHOD</u>	<u>APPLICATION FEE</u>
Registered Occupational Therapist	056	Acceptance of Examination	\$ 25.00
Certified Occupational Therapy Assistant	057	Acceptance of Examination	\$ 25.00
Registered Occupational Therapist	056	Endorsement of License	\$ 25.00
Certified Occupational Therapy Assistant	057	Endorsement of License	\$ 25.00
Registered Occupational Therapist	056	Restoration	See Supporting Document <b>RS</b>
Certified Occupational Therapy Assistant	057	Restoration	See Supporting Document <b>RS</b>

## CHART II - EXAMINATION CODES AND FEES

NOT APPLICABLE FOR REGISTERED OCCUPATIONAL THERAPIST  
OR CERTIFIED OCCUPATIONAL THERAPY ASSISTANT  
ENTER N/A IN PART VII a) OF APPLICATION  
FOR LICENSURE AND/OR EXAMINATION

## CHART III - EXAMINATION DATES AND LOCATION

NOT APPLICABLE FOR REGISTERED OCCUPATIONAL THERAPIST  
OR CERTIFIED OCCUPATIONAL THERAPY ASSISTANT  
ENTER N/A IN PART VII b) OF APPLICATION  
FOR LICENSURE AND/OR EXAMINATION

## CHART IV - SCHOOL CODES

NOT APPLICABLE FOR REGISTERED OCCUPATIONAL THERAPIST  
OR CERTIFIED OCCUPATIONAL THERAPY ASSISTANT  
ENTER N/A IN PART VII c) OF APPLICATION  
FOR LICENSURE AND/OR EXAMINATION

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

If assistance is needed, direct your request to one of the following telephone numbers:

**DPR Call Center - 1-800-560-6420**

**TTY - 1-866-325-4949**

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Occupational Therapists or Occupational Therapy Assistants

*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	
CCA Supporting Document CCA <b>must</b> be completed and submitted with each application. Your application will not be processed without completion of this form.	
<b>CT</b> (Certification of Licensure) Form completed by original jurisdiction and current jurisdiction (if applicable)	
<b>ED</b> Form--Verifying graduation from an approved Occupational Therapy program	
<b>N.B.C.O.T. Examination:</b> Proof of passage of the examination as administered by the N.B.C.O.T. with a score of 450 or above (if applicable)	
<b>CE Form</b> --Proof of 24 hours of C.E. if restoring license	
<b>RS Form is required if restoring an expired or inactive license</b> (complete in all applicable areas)	
Copy of <b>DD214</b> if restoring license from active military service	

**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.<br><br><input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.<br><br><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.<br><br><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. ____ - ____ - ____
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4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
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5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY	ZIP CODE	COUNTY
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6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
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8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH ____ / ____ / ____ Month Day Year	10. AGE <input type="checkbox"/> Female <input type="checkbox"/> Male
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11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) _____ - _____ Home: (____) _____ - _____ (Area Code) (Area Code) Fax: (____) _____ - _____ Fax: (____) _____ - _____ (Area Code) (Area Code)	12. <b>REQUIRED</b> E-MAIL ADDRESS
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NAME (Last, First, MI):

SS#:

Profession:

**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      Received OR 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	

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	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**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.)*

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. <i>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.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
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? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
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? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

PART VII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)
<p>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. <b>Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</b></p> <p>Are you more than 30 days delinquent in complying with a child support order? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>(NOTE: If you are not subject to a child support order, answer "no.")</i></p>
<p>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."</p> <p>Are you delinquent in the filing of state taxes? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

PART VIII: Certifying Statement
<p>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.</p> <p>_____</p> <p style="text-align: center;">Signature of Applicant</p> <p>_____</p> <p style="text-align: center;">Date</p> <p><b>I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.</b> 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.</p>

**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.**

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

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? *  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? *  | <input type="checkbox"/> | <input type="checkbox"/> |

*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.

**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) <input type="checkbox"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____	
<input type="checkbox"/> Endorsement of License (State) _____ <input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather _____ <input type="checkbox"/> Credentials _____ <input type="checkbox"/> Other (Describe) _____	
Acceptance of Examination Results _____ (Administered in Another State)	

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) _____ _____ _____	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:

**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.

SUPPORTING DOCUMENT

## CERTIFICATION OF EDUCATION

# 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ To \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day     Year                          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 \_\_\_\_/\_\_\_\_/\_\_\_\_       Applicant has completed program on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day     Year    Month   Day     Year  
 Applicant will graduate on \_\_\_\_/\_\_\_\_/\_\_\_\_       Applicant will complete program on \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month   Day     Year    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.

NAME (Last, First, MI):

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

SS#:

\_\_\_\_\_

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\_\_.

Profession:

\_\_\_\_\_

Date of Expiration

\_\_\_\_\_

Signature of Notary Public

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

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