INSTRUCTION SHEET

FOR MAKING APPLICATION UNDER PROVISIONS OF THE ILLINOIS DENTAL PRACTICE ACT

RESTRICTED FACULTY LICENSE
TEMPORARY DENTAL TRAINING LICENSE

In order for your application to be processed, all required supporting documentation must be submitted, with the application and required fee unless otherwise directed in the instructions.

BEFORE COMPLETING THE APPLICATION PACKAGE, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in accurately completing your application and eliminate delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT.

Step 1. Select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, from the chart below and record the information in Part I (page one) of the Application for Licensure and/or Examination.

<table>
<thead>
<tr>
<th>Professional Fee</th>
<th>Professional Code</th>
<th>Licensure Method</th>
<th>Application Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restricted Faculty License</td>
<td>136</td>
<td>Nonexamination</td>
<td>$250.00</td>
</tr>
<tr>
<td>Restricted Faculty License</td>
<td>136</td>
<td>Renewal of License</td>
<td>$150.00</td>
</tr>
<tr>
<td>Temporary Dental Training License</td>
<td>018</td>
<td>Nonexamination</td>
<td>$150.00</td>
</tr>
</tbody>
</table>

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

NOTE: a) Indicate both Pre-Dental and Dental Education in PART III, number 6, on the Application for Licensure and/or Examination.

b) DO NOT COMPLETE PART VII (page four) of the Application for Licensure and/or Examination.

Step 3. The remainder of this form contains specific instructions for your Licensure Method.

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

Step 4. If needed, call 1-800-560-6420 or (TDD) - 1-866-325-4949 for assistance in completing the application package. Please allow 4 weeks from mailing your application before making an inquiry concerning its status.

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

DPR-DN-T 03/15

Packet updated 4/10/20
NOTE: In accordance with the provisions outlined in the Dental Practice Act, restricted faculty licenses are valid for a period of three (3) years and may be extended or renewed. The holder of a restricted faculty license may practice general dentistry or in his/her area of specialty, but only in a clinic or office affiliated with the dental school.

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

2. Supporting Document CT must be completed by the jurisdiction or country of original licensure and the jurisdiction or country of current licensure where you have most recently been practicing, if applicable. You must direct the licensing agency/board to return completed form CT directly to you for inclusion with your application.

3. Supporting Document DN-TT must be completed showing applicant has a full-time appointment to teach dentistry at an approved dental school or hospital situated in Illinois. Form must be signed by the Dean of the school or hospital administrator. Direct the school/hospital to return completed form directly to you.

4. 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 page 1, Step 1.)

5. 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.

RENTERIAL OF RESTRICTED FACULTY LICENSE

In order for your application to be processed, ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED with the application and required fee unless otherwise directed in the instructions.

Application for renewal of a restricted faculty license shall be made on forms supplied by the Department at least 60 days prior to expiration of the license. The application shall include:

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

2. Four page Application for Licensure and/or Examination;

3. Supporting Document DN-TT completed by the Dean of a dental program or administrator of the hospital indicating the term of the renewal contract, not to exceed three (3) years from the date of the original expiration date. Form should be returned directly to you for inclusion with the application.

4. Supporting Document CT must be completed by the jurisdiction of current licensure indicating the current status of the license. You must direct the licensing agency/board to return completed form CT directly to you.

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 page 1, Step 1).

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.
Read the following information and then follow the instructions under which you qualify:

1. You should file your application for licensure upon acceptance into the residency or specialty program.

2. Pursuant to the provisions of the Illinois Dental Practice Act, you will be permitted to practice dentistry prescribed by and incidental to the program for a period of three (3) months from the starting date of the program without licensure when an application, in form and substance acceptable to the Department, has been filed with the Department.

   You must file Supporting Document CA-DEN to practice prior to the issuance of your license.

3. The authorization to practice will not affect the decision on licensure. The authorization to practice will be terminated upon denial of the application.

   **NOTE:** If you are a graduate of a dental program accredited by the Commission on Dental Accreditation of the American Dental Association follow these instructions only.

   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-DEN must be completed in its entirety by the Dean or Registrar of the dental school from which you graduated. Completed document must have school seal affixed. This form must be submitted with your application.

   3. If you wish to pursue a specialty or other advanced clinical education program in an approved dental school or hospital situated in Illinois, or to pursue a program of specialty training in a dental public health agency in Illinois, you may qualify for a temporary training license. Supporting Document CA-DEN must be completed verifying you have been accepted or appointed for special/residency training. Direct the Dean/Hospital Administrator of the Specialty or Residency program to forward the completed form to you for inclusion with your application.

   4. If you have ever held a license as a dentist or a related license, Supporting Document CT must be completed by 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 to you for inclusion with your application.

   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 page 1, Step 1.)

   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.

   **NOTE:** If you are a graduate of a dental program that is not approved by the Commission on Dental Accreditation you must follow these instructions.

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

   2. Supporting Document ED-DEN must be completed in its entirety by the Dean or Registrar of the dental school from which you graduated. Completed document must have school seal affixed. This form must be submitted with your application.

   3. Submit an official transcript from your pre-dental and dental college or professional institution with school seal affixed.

   4. If you wish to pursue a specialty or other advanced clinical education program in an approved dental school or hospital situated in Illinois, or to pursue a program of specialty training in a dental public health agency in Illinois, you may qualify for a temporary training license. Supporting Document CA-DEN must be completed verifying you have been accepted or appointed for special/residency training. Direct the Dean/Hospital Administrator of the Specialty or Residency program to forward the completed form to you for inclusion with your application.

   5. If you have ever held a license as a dentist or a related license, Supporting Document CT must be completed by 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 for inclusion with your application.

   6. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. (See page 1, Step 1.)

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

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

<table>
<thead>
<tr>
<th>Licensure Methods</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>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.</td>
</tr>
<tr>
<td>Endorsement of License</td>
<td>Original license issued in another state and that state’s requirements were substantially equivalent to Illinois requirements at time license was issued.</td>
</tr>
<tr>
<td>Acceptance of Examination</td>
<td>Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.</td>
</tr>
<tr>
<td>Restoration</td>
<td>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.</td>
</tr>
<tr>
<td>Grandfather/Waiver</td>
<td>Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).</td>
</tr>
<tr>
<td>Non-examination</td>
<td>Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.</td>
</tr>
</tbody>
</table>
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!

## FOUR-PAGE APPLICATION REVIEW

<table>
<thead>
<tr>
<th>Part I.</th>
<th>Application Category Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part II.</td>
<td>Applicant Identifying Information</td>
</tr>
<tr>
<td>Part III.</td>
<td>Education Information</td>
</tr>
<tr>
<td>Part IV.</td>
<td>Record of Licensure Information</td>
</tr>
<tr>
<td>Part V.</td>
<td>Record of Examination</td>
</tr>
<tr>
<td>Part VI.</td>
<td>Personal History Information</td>
</tr>
<tr>
<td>Part VII.</td>
<td>Examination Coding Information (if applicable)</td>
</tr>
<tr>
<td>Part VIII.</td>
<td>Child Support and/or Student Loan Information</td>
</tr>
<tr>
<td>Part IX.</td>
<td>Certifying Statement--Signed and Dated</td>
</tr>
</tbody>
</table>

## SUPPORTING DOCUMENTS--RESTRICTED FACULTY

Application Fee.

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

DN-TT (Certification of Appointment for Restricted Faculty License) completed by the Dean or hospital administrator for faculty appointment to teach dentistry for which you have been accepted.

CT (Certification of Licensure) Form completed by the jurisdiction or country of original licensure and the jurisdiction or country of current licensure where you have most recently been practicing.

## SUPPORTING DOCUMENTS--TEMPORARY TRAINING LICENSE

Application Fee.

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

ED-DEN Form with school seal affixed.

Official transcripts from pre-dental and dental college or professional institution with school seal affixed.

CA-DEN (Certification of Acceptance for Specialty/Residency Training) completed by the dental school/public health agency/hospital in this State that accepted you for specialty/residency training with seal affixed.

CT (Certification of Licensure) Form completed by the jurisdiction of current licensure where you have most recently been practicing.

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

IL486-1971 (DN-RFL TTL 02/15)
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.

**PART I: Application Category Information**

A. Check the box indicating the appropriate information regarding your application. 
- [ ] Military
- [ ] Military Spouse
- [ ] Not Military
- [ ] Decline to Answer

Military service member is defined as: “Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application.” The following will be considered proof of you or your spouse’s active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember’s electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

**PART II: Applicant Identifying Information**

- Check the box indicating the appropriate information regarding your application.
  - [ ] This is the first time I have made application for this profession in Illinois.
  - [ ] I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
  - [ ] Other: 

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- [ ] My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- [ ] I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

**PART III: Personal 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
- [ ] 5. Business Address
- [ ] 6. Maiden, Given Surname, or Any Name(S) Under Which Supporting Documents Will Be Submitted.
- [ ] 7. Mother’s Maiden Name
- [ ] 8. Place of Birth
- [ ] 9. Date of Birth
- [ ] 10. Age
- [ ] 11. Telephone Number Where You May Be Reached
  - Work: (______) _______ _______
  - Home: (______) _______ _______
  - Fax: (______) _______ _______
  - Fax: (______) _______ _______
- [ ] 12. Required E-mail Address

**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.

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.

The social security number may be provided to the Illinois Department of Revenue, or to other entities for verification of identification. Disclosure of this information is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. 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. Failure to comply may result in this form not being processed. Additional application forms can be downloaded from the IDFPR web site at www.idfpr.com.
### PART III: Education Information

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

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduated High School?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received OR G.E.D.?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Graduated?</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. **COLLEGE OR UNIVERSITY NAME** (Undergraduate and Graduate)

<table>
<thead>
<tr>
<th>LOCATION (City and State or Country)</th>
<th>DATES OF ATTENDANCE FROM</th>
<th>TO</th>
<th>TYPE OF DEGREE EARNED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month/Year</td>
<td>Month/Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>INSTITUTION NAME</th>
<th>LOCATION (City and State or Country)</th>
<th>DATES OF ATTENDANCE FROM</th>
<th>TO</th>
<th>Did You Complete Training?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Month/Year</td>
<td>Month/Year</td>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**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.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROFESSION NAME</th>
<th>LICENSE NUMBER</th>
<th>DATE OF ISSUANCE</th>
<th>LICENSE STATUS (Active, Lapsed, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>State of Original Licensure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State of Current Licensure where you most recently have been practicing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other States of Licensure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>NAME OF EXAMINATION</th>
<th>STATE</th>
<th>MONTH/YEAR</th>
<th>EXAM RESULTS (Passed, Failed, Absent)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If additional space is needed, attach a separate sheet.)
PART VI: Personal History Information  *(This part must be completed by all applicants)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</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 <em>no</em>,附上一份详细描述情况的个人声明以及法院记录的复印件。一般情况下，刑事定罪本身并不导致执照被拒绝。</td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>3. If <em>yes</em>, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If <em>yes</em>,附上证书复印件。</td>
<td></td>
<td></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 <em>yes</em>,附上一份详细声明，包括解释你目前是否正在接受治疗。</td>
<td></td>
<td></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 <em>yes</em>,附上解释。</td>
<td></td>
<td></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 <em>yes</em>,附上解释。</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART VII: Child Support and Tax Information *(Every applicant is required by law to respond to the following questions)*

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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. <strong>Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(NOTE: If you are not subject to a child support order, answer &quot;no.&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. In accordance with 20 ILCS 2105-15(g), &quot;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.&quot;</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PART VIII: 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.
### 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**

- Examination (Administered in Your State)
- National (Name)
- State Constructed
- Other (Name)
- Endorsement of License (State)
- Acceptance of Examination Results (Administered in Another State)
- Reciprocity with (State) ____________
- Waiver/Grandfather Credentials
- Other (Describe) ____________

F. **CURRENT LICENSURE STATUS**

- Active
- Inactive
- Lapsed
- Other (Explain) ____________

G. **IF LICENSED BY EXAMINATION, RECORD SCORES**

- Type of Examination
  - Written
  - Practical
  - Other (Describe) ____________
- Score
- Received no Grade Below
- Examination Period _____ days _____ hours
### PART III - CERTIFICATION OF EXAMINATION SCORES

**A1. National or other Profession Specific Examination**

<table>
<thead>
<tr>
<th>Scaled Score</th>
<th>Raw Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Deviation</th>
<th>Corrected Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Mean</th>
<th>Percent Score</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of Examination**

(Record all available information)

**A2.**

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DATE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DATE</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

---

Print Name: 

Title: 

Agency/Board Street Address: 

City, State, ZIP Code: 

Signature: 

Date: 

Area Code ( ) Telephone Number: 

---

Attention Licensing Agency/Board: RETURN THIS FORM TO THE APPLICANT.

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.
IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 25/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

NOTE: An applicant who has filed an Application for Licensure and/or Examination with the Department and has met all requirements for licensure will be permitted to practice dentistry for a period of 3 months from the starting date of the program, unless authorized in writing by the Department to continue such practice for a period specified in writing by the Department. The authority to practice shall terminate immediately upon: (1) the decision of the Department that the applicant has failed the examination; or (2) denial of licensure by the Department; or (3) withdrawal of the application.

APPLICANT: Complete the applicant section of this form, then forward it to the dental school/public health agency/hospital that has accepted you for specialty/residency training, for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE
2. DATE OF BIRTH
   ______/_____/____
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

ADMINISTRATOR: Complete the remainder of this form, then return the form to the applicant.

A. DENTAL SCHOOL/HOSPITAL/INSTITUTION NAME
B. BEGINNING DATE
   ______/_____/____
C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
D. ENDING DATE
   ______/_____/____
E. BUSINESS TELEPHONE NUMBER
   Area Code (_____)____-____
F. SPECIALTY/RESIDENCY NAME
G. YEAR OF POSTGRADUATE TRAINING

I do hereby declare that the above-named applicant has been accepted or appointed for specialty/residency training as indicated above. Upon notification that the applicant has failed the examination; or licensure is denied by the Department; or the application is withdrawn, I understand the authority to practice shall terminate immediately.

Signature of Dean/Hospital Administrator

S E A L

Print Name of Dean/Hospital Administrator

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

   - Profession Name  
   - Profession Code

6. **MAIDEN OR GIVEN SURNAME**

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 completed form to applicant. Pre-dated forms will not be accepted.

<table>
<thead>
<tr>
<th>A. NAME OF INSTITUTION</th>
<th>B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. DEPARTMENT OF INSTITUTION</th>
<th>D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E. MAJOR AREA OF STUDY OF THE APPLICANT</th>
<th>F. APPLICANT WAS (CHECK ONE):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-time  Part-time</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>G. CREDIT HOURS Earned (CHECK ONE AND COMPLETE)</th>
<th>H. DATES OF ATTENDANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __</td>
</tr>
<tr>
<td>______ Semester Hours  ______ Quarter Hours</td>
<td>Month  Day  Year</td>
</tr>
<tr>
<td>______ Course Hours</td>
<td>Month  Day  Year</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I. Total academic years attended OR</th>
<th>J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., Ph.D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total calendar years attended</td>
<td></td>
</tr>
<tr>
<td>__ __ / __ __ / __ __ __ __</td>
<td></td>
</tr>
<tr>
<td>Years  Months  Days</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>K. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE</th>
<th>L. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Certification of Education - Page 1 of 2**
I certify that the information recorded herein is true and correct according to the official records of this institution. I also certify that the applicant has achieved the same level of scientific knowledge and clinical competence as required of all graduates of this institution.

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Print Name of School Official: __________________________________

Signature of School Official: ________________________________

SCHOOL SEAL OR NOTARY SEAL

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

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

Date of Expiration: ________________________________

Signature of Notary Public: ________________________________

RETURN THIS FORM TO APPLICANT