## INSTRUCTIONS

FOR MAKING APPLICATION UNDER PROVISIONS OF THE

**ILLINOIS OPTOMETRIC ACT**

Acceptance of Examination
Endorsement
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.*

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 completing your application accurately and eliminate any delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT. If you are issued a license, please be advised that your license will expire March 31st of each even-numbered year.

### Step 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**.

### 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**.

### Step 3.
The remainder of this form contains specific instructions for each Licensure Method. Locate the instructions for the Licensure Method you recorded on **PART I** (page one), of the **Application for Licensure and/or Examination** and follow those instructions only.

**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, telephone numbers for assistance in completing the Application Package are provided on the **REFERENCE SHEET**.

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Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Pharmaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.

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

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: Complete and return this application and all supporting documents and instruct the National Board of Examiners in Optometry (N.B.E.O.) to forward your scores directly to the Department when you have successfully completed all parts of the National Board including passage of the Treatment and Management of Ocular Disease (T.M.O.D.).

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 by the dean or registrar of the optometry education program attended with the school seal affixed. Must be submitted with each application.


6. If you graduated January 1, 2008 and forward, only Supporting Document ED is required.

7. If you have ever been licensed as an optometrist, Supporting Document CT must be completed by the jurisdiction of the original licensure and current licensure which you have been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form CT directly to you.

8. A certified copy of your National Board of Examiners in Optometry (NBEO) score must be sent directly to this Division from NBEO indicating that you passed both parts of the written theoretical examination, including TMOD, and the clinical skills examination.

9. Fee payment is indicated on the REFERENCE SHEET, CHART I. Fee payment must be in the form of a check or money order made payable to Department of Financial and Professional Regulation.


Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Pharmaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.
NOTE: Based on the Illinois Optometric Licensing and Disciplinary Board evaluation of your application and supporting documents, you may be required to submit additional documentation. Your application evaluation is based upon the equivalency of your examination results in the previous jurisdiction compared to the Illinois examination administered the same year.

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 by the dean or registrar of the optometry education program attended with the school seal affixed. Must be submitted with each application.


6. If you graduated January 1, 2008 and forward, only Supporting Document **ED** is required.

7. If you have ever been licensed as an optometrist, Supporting Document **CT** must be completed by the jurisdiction of the original licensure and current licensure which you have been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** directly to you.

8. A certified copy of your National Board of Examiners in Optometry (NBEO) score must be sent directly to this Division from NBEO indicating that you passed both parts of the written theoretical examination, including TMOD, and the clinical skills examination.

9. Submit a copy of the licensing Acts and Rules for registration in the jurisdiction of original licensure for the time you were licensed.

10. Fee payment is indicated on the **REFERENCE SHEET, CHART I**. Fee payment must be in the form of a check or money order made payable to Department of Financial and Professional Regulation.


Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Phamaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.
OPTOMETRY 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 optometrists whose licenses have been on inactive status, or in non-renewed status, for three or more years.

If your license has been inactive, or in non-renewed status, for less than three 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.

NOTE: Based on the Illinois Optometric Licensing and Disciplinary Board evaluation of your application and supporting documents, you may be required to submit additional documentation.

1. Supporting Document CCA must be completed. If this form was not included in the application packet, they must obtain one by contacting the DPR Call Center at 1-800-560-6420.

2. Supporting Document RS must be completed by each state in which you have ever been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form CT directly to the address indicated in number 9 below.

3. Submit one of the following documents:
   a) Supporting Document CT must be completed by the jurisdiction of original licensure and current licensure in which they have been issued a license. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return the completed form CT directly to you. AND
   Supporting Document VE must be completed by your employer to verify current active practice in another jurisdiction. If self-employed, complete the document on your own behalf. If this form is not included in the application packet, the applicant must obtain one by contacting the Division of Professional Regulation at 1-800-560-6420. OR
   b) If restoring after active military service, submit a copy of DD214.

4. If unable to submit supporting documents VE or form DD214, proof of completion of one of the following must be submitted:
   a) Evidence of other education or other experience acceptable to the Division of the licensee's fitness to have the certification restored. Such evidence shall be reviewed on a case by case basis by the Board; OR
   b) Certification of passage of Part III of the examination administered by the NBEO.

5. Submit the following documents:
   a) Evidence of an existing Therapeutic Pharmaceutical agent certification at the time license was placed in inactive or expired status; AND
   b) Proof of completion of the Oral Pharmaceutical Agents requirement pursuant to Section 1320.335 of the Rules.

6. All applicants for Restoration of optometry license in Illinois must submit proof of having met the 30-hour requirement of continuing education during the 2 years prior to restoration. This must be verified by submission of certificates of attendance provided by approved sponsors of continuing education programs.

7. Proof of current certification in cardiopulmonary resuscitation (CPR).

8. 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.


Applicants applying for licensure on the basis of Acceptance of Examination, Endorsement or Restoration must be eligible for Diagnostic Ocular Pharmaceuticals (TN-D-OPT), Topical Therapeutics (TN-T-OPT) and Oral Therapeutic Medications (TN-T-OPT Oral Therapeutics).

Those doctors wishing to prescribe controlled substance medications must complete and return the enclosed Illinois Controlled Substance application and upon issuance may apply for a DEA license.
## 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."
# 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

<table>
<thead>
<tr>
<th>PROFESSION NAME</th>
<th>PROFESSION CODE</th>
<th>LICENSURE METHOD</th>
<th>APPLICATION FEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Optometrist</td>
<td>046</td>
<td>Acceptance of Examination</td>
<td>$500.00</td>
</tr>
<tr>
<td>Registered Optometrist</td>
<td>046</td>
<td>Endorsement</td>
<td>$500.00</td>
</tr>
<tr>
<td>Registered Optometrist</td>
<td>046</td>
<td>Restoration</td>
<td>See Supporting Document RS</td>
</tr>
</tbody>
</table>

## CHART II - EXAMINATION CODES AND FEES

NOT APPLICABLE FOR OPTOMETRIST

ENTER N/A IN PART VII a) OF APPLICATION FOR LICENSURE AND/OR EXAMINATION

## CHART III - EXAMINATION DATES AND LOCATION

NOT APPLICABLE FOR OPTOMETRIST

ENTER N/A IN PART VII b) OF APPLICATION FOR LICENSURE AND/OR EXAMINATION

## CHART IV - SCHOOL CODES

NOT APPLICABLE FOR OPTOMETRIST

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.
Application Checklist for Optometry

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!

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

<table>
<thead>
<tr>
<th>SUPPORTING DOCUMENTS</th>
<th>SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee</td>
<td></td>
</tr>
</tbody>
</table>

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

CT (Certification of Licensure) Form completed by **each** jurisdiction of licensure

ED Form completed by school showing graduation from an approved Optometric program

TN-D-OPT (if applicable)

TN-T-OPT (120 hours) (if applicable)

TN-T-Orals (Orals) (if applicable)

C.E. (18 approved regular hours and 12 approved TQ hours) (if applicable)

Copy of DD214 if restoring license from active military service

RS (Restoration) Form--Form is required if restoring an expired or inactive license (complete all applicable sections)

VE (if applicable)

CT Form; or DD214; or proof of examination or education program

All supporting documents **may not be required**. Please refer to application instructions for your specific method of licensure.
APPLICATION FOR LICENSURE AND/OR EXAMINATION

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. 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.

B. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

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.

A. Type or print legibly with black ink only.

1. NAME LAST FIRST MIDDLE
2. TITLE (e.g., M.D., D.D.S., etc.)
3. UNITED STATES SOCIAL SECURITY NO.

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

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)

7. MOTHER’S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY

9. DATE OF BIRTH Month Day Year

10. AGE [ ] Female [ ] Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (_______) _______ - _______ _______ Home: (_______) _______ - _______ _______
(Final Code) (Area Code) (Area Code)

Fax: (_______) _______ - _______ _______ Fax: (_______) _______ - _______ _______
(Final Code) (Area Code) (Area Code)

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.

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</td>
<td>No</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Received OR G.E.D.?</td>
<td>Yes</td>
<td>No</td>
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</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</td>
<td>No</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

   | DATE OF ATTENDANCE | TYPE OF DEGREE EARNED |
   | FROM | TO |
   | Month/Year | Month/Year |

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>DATE OF ATTENDANCE FROM</th>
<th>TO</th>
<th>Did You Complete Training?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Month/Year</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
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<td>Month/Year</td>
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<td>Yes</td>
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<td>Yes</td>
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<td></td>
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<td>Month/Year</td>
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<td>Yes</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>
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<td></td>
</tr>
<tr>
<td>Other States of Licensure</td>
<td></td>
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</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>
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<td></td>
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</tbody>
</table>

(If additional space is needed, attach a separate sheet.)
**PART VI: 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.**

   1. **Yes**
   2. **No**

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.**

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.**

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.**

**PART VII: 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?**
   **Yes**
   **No**

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

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?**
   **Yes**
   **No**

**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.
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       ☐ Naprapaths
☐ Advanced Practice Registered Nurses       ☐ Occupational Home Administrators       ☐ Physician Assistants
☐ Athletic Trainers       ☐ Occupational Therapists       ☐ Podiatrists
☐ Audiologists       ☐ Occupational Therapy Assistants       ☐ Professional Counselors
☐ Clinical Psychologists       ☐ Optometrists       ☐ Prosthetists
☐ Clinical Social Workers       ☐ Orthotists       ☐ Registered Nurses
☐ Dental Hygienists       ☐ Pedorthists       ☐ Registered Surgical Assistants
☐ Dentists       ☐ Perfusionists       ☐ Registered Surgical Technologists
☐ Genetic Counselors       ☐ Pharmacists       ☐ Respiratory Care Practitioners
☐ Licensed Clinical Professional Counselors       ☐ Physical Therapists
☐ Licensed Practical Nurses       ☐ Physical Therapy Assistants
☐ Licensed Social Workers       ☐ Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.)
☐ Marriage and Family Therapists       ☐ 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.
☐ Medication Aide

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? *
   Yes ☐ No ☐

2) Are you currently charged with or have 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__________________________

IL486-2034  06/19 (crimacts)
**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),
   - 11-26 (grooming),
   - 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.

2. (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).

3. (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.

4. (1.7) Blank.

5. (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.

6. (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.

7. (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).

8. (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).

9. (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.

10. (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);
i) 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.
This page intentionally left blank for double-sided printing.
**PART I - CERTIFICATION OF EXAMINATION STATUS**

A. The applicant ☐ has written ☐ is scheduled to write the following examination:

<table>
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<tr>
<th>Name of Examination</th>
<th>Date of Examination</th>
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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

F. CURRENT LICENSURE STATUS

- [ ] Active
- [ ] Inactive
- [ ] Lapsed
- [ ] Other (Explain)

G. IF LICENSED BY EXAMINATION, RECORD SCORES

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<thead>
<tr>
<th>Type of Examination</th>
<th>Score</th>
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<td>Written</td>
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<td>Practical</td>
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<tr>
<td>Other (Describe)</td>
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</table>

Received no Grade Below

Examination Period _______ days _______ hours
### PART III - CERTIFICATION OF EXAMINATION SCORES

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<th>SCORE</th>
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<th>SCORE</th>
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### 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?  
   - [ ] Yes  [ ] No  
   (If yes, attach a certified copy of disciplinary action.)

### 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

______________________________________________  
Area Code (               )  
Date

______________________________________________  
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 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**CERTIFICATION OF EDUCATION**

**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**

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.

**SCHOOL OFFICIAL:** Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

<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>C. DEPARTMENT OF INSTITUTION</td>
<td>D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT</td>
</tr>
</tbody>
</table>
| 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) | H. DATES OF ATTENDANCE
   - From Month / Day / Year To Month / Day / Year |
| I. Total academic years attended OR Total calendar years attended | 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 | L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED
   - Month / Day / Year |
| M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE | N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:
   - Applicant has graduated on Month / Day / Year
   - Applicant has completed program on Month / Day / Year
   - Applicant will graduate on Month / Day / Year
   - Applicant will complete program on Month / Day / Year

IL486-1306 03/06 (LT) ED - 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.

_________________________                                    ___________________________
Print Name of School Official                                        Signature of School Official

_________________________
Title

_________________________
Date

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

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.
**VERIFICATION OF EMPLOYMENT / EXPERIENCE**

**APPLICANT:** Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. 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. **JOB TITLE OR POSITION APPLICANT HELD**

8. **DATES OF EMPLOYMENT**
   - From __ __/ __ __ / __ __ __ __
   - To __ __ / __ __ / __ __ __ __

9. **SUPERVISOR NAME**

**EMPLOYER:** Complete the remainder of this form. Return the completed form to the applicant in a sealed envelope.

**PART I - EMPLOYMENT INFORMATION**

A. **EMPLOYER NAME**

B. **BUSINESS / INSTITUTION NAME**

C. **EMPLOYER REGISTRATION/LICENSE NUMBER**

D. **STATE OF EMPLOYER REGISTRATION/LICENSE**

E. **BUSINESS ADDRESS**
   - STREET
   - CITY
   - STATE
   - ZIP CODE

F. **BUSINESS REGISTRATION/LICENSE NUMBER** (If Applicable)

G. **STATE OF BUSINESS REGISTRATION/LICENSE**

H. **BUSINESS TELEPHONE NUMBER**
   - Area Code (___ ___ ___) ___ ___ ___ ___

**PART II - APPLICANT EMPLOYMENT INFORMATION**

A. **NUMBER OF HOURS WORKED PER WEEK**

B. **TYPE OF EMPLOYMENT**
   - [ ] Full-time
   - [ ] Part-time

C. **DATES OF EMPLOYMENT**
   - From __ __/ __ __ / __ __ __ __
   - To __ __ / __ __ / __ __ __ __

D. **RECORD APPLICANT’S POSITION TITLE(S)**

E. **GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT.**

I do hereby declare that this information is true and correct.

________________________
Signature

________________________
Date

________________________
Title
**APPLICANT:** Complete the applicant section of this form. Forward form to the individual who will certify your training.

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.

<table>
<thead>
<tr>
<th>Profession Name</th>
<th>Profession Code</th>
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<tr>
<td>OPTOMETRY</td>
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</table>

6. **MAIDEN OR GIVEN SURNAME**

7. **DATES OF TRAINING**
   
   From ___/___/_____ To ___/___/____

8. **COURSE TITLE / INSTITUTION**

---

**CERTIFYING OFFICIAL:** Complete the remainder of this form. RETURN THE COMPLETED APPLICATION TO THE APPLICANT.

A. **CERTIFYING OFFICIAL**

B. **INSTITUTION NAME**

C. **INSTRUCTOR JOB TITLE / PROFESSION NAME**

D. **INSTITUTION STREET ADDRESS**

E. **INSTITUTION TELEPHONE NUMBER**

   Area Code (_______)_______-_______

F. **INSTITUTION CITY, STATE, ZIP CODE**

G. **APPLICANT’S TRAINING DATES**
   
   From ___/___/_____ To ___/___/____

H. **TRAINING CLOCK HOURS APPLICANT**

I. **DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?**
   
   [ ] Yes  [ ] No

J. **IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.**
K. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

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

Print Name of School Official

Signature of School Official and/or Director/Administrator of Training Programs

Title

Date

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

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.
**APPLICANT:** Complete the applicant section of this form. Forward the form to the individual who will certify your training. This form must be completed for individuals graduating after January 1, 1994.

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**

7. **DATES OF TRAINING**
   - From __/__/____
   - To __/__/____
   - Month
   - Day
   - Year
   - Month
   - Day
   - Year

8. **COURSE TITLE / INSTITUTION**

---

**CERTIFYING OFFICIAL:** Complete the remainder of this form. RETURN COMPLETED FORM TO APPLICANT.

**A. CERTIFYING OFFICIAL**

**B. INSTITUTION NAME**

**C. INSTRUCTOR JOB TITLE/PROFESSION NAME**

**D. INSTITUTION STREET ADDRESS**

**E. INSTITUTION TELEPHONE NUMBER**

   - Area Code ( ____ ____ ____ ) ____ ____ ____ - ____ ____ ____

**F. INSTITUTION CITY, STATE, ZIP CODE**

**G. APPLICANT'S TRAINING DATES**

   - From __/__/____
   - To __/__/____
   - Month
   - Day
   - Year
   - Month
   - Day
   - Year

**H. TRAINING CLOCK HOURS APPLICANT**

**I. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?**

   - Yes
   - No

**J. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.**
I certify that this applicant for Illinois licensure has successfully completed 30 hours of therapeutic ocular training in systemic disease. The subject areas were:

a. Cardiovascular
b. Respiratory Disorders (e.g. Pulmonary)
c. Immunology
d. Infectious Disease
e. Dermatology
f. Cataract Surgery - 2 hours maximum
g. General Medical Emergency
h. Endocrinology
i. Collagen Vascular Disease

Name of Instructor

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
**CERTIFYING OFFICIAL:** Complete the remainder of this form. RETURN THE COMPLETED FORM TO THE APPLICANT.

**APPLICANT:** Complete the applicant section of this form. Forward form to the individual who will certify your training. Training must have been obtained after January 1, 1994.

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<th>1. NAME LAST</th>
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<th>MIDDLE</th>
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<th>2. DATE OF BIRTH</th>
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<td>Month / Day / Year</td>
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<th>4. ADDRESS STREET, CITY, STATE, ZIP CODE</th>
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<th>7. DATES OF TRAINING</th>
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<th>8. COURSE TITLE / INSTITUTION</th>
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**CERTIFYING OFFICIAL:** Complete the remainder of this form. RETURN THE COMPLETED FORM TO THE APPLICANT.

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<th>F. INSTITUTION CITY, STATE, ZIP CODE</th>
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<table>
<thead>
<tr>
<th>G. APPLICANT’S TRAINING DATES</th>
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<tbody>
<tr>
<td>From Month / Day / Year To Month / Day / Year</td>
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<thead>
<tr>
<th>H. TRAINING CLOCK HOURS APPLICANT</th>
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<tr>
<th>I. DID APPLICANT SUCCESSFULLY COMPLETE TRAINING COURSE?</th>
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<td>Yes</td>
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<tr>
<th>J. IF TRAINING WAS OBTAINED OUTSIDE OF AN INSTITUTION FACILITY, INDICATE THE SETTING(S) IN WHICH TRAINING WAS OBTAINED.</th>
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K. RECORD ANY ADDITIONAL COMMENTS YOU WISH TO MAKE REGARDING THE APPLICANT'S TRAINING.

I. At least 60 hours taught by faculty members of the college or university sponsoring the course in the following subject areas:

1. Anatomy and Physiology Considerations in Ocular Disease - 5 hours minimum
2. Pharmacology of Therapeutic Agents - 10 hours minimum
3. Specific Ocular Disease Considerations - 15 hours minimum
   a. Bacterial
   b. Viral and Chlamydial
   c. Allergic
   d. Fungal
   e. Clinical Diagnosis and Treatment of Anterior Uveitis
   f. Clinical Diagnosis and Management of Posterior Uveitis
   g. Lacrimal Disorders

II. Other Ocular Diseases/Disorders - 15 hours minimum

   a. Pre-Post Operative Cataract Care
   b. Integration of Nervous System Assessment and Neuro-Ophthalmic Disorders
   c. Practical Management of Ocular Emergencies
   d. Diabetic Complications - Diabetic Retinopathy
   e. Sudden Vision Loss

III. Glaucoma Diagnosis, Treatment and Management - 10 hours minimum

   a. Pathophysiology of Glaucoma
   b. Open Angle Glaucoma
   c. Angle Closure Glaucoma

IV. Clinical Laboratory Tests and Services - 3 hours minimum

   At least 30 hours of Clinical Medical Perspectives/Primary Care Medicine for the Ophthalmic Practitioner that shall be taught by medical faculty members. The 30 hours shall be in the following areas:

   a. Cardiovascular
   b. Respiratory Disorders (e.g. Pulmonary)
   c. Immunology
   d. Infectious Disease
   e. Dermatology
   f. Cataract Surgery - 2 hours maximum
   g. General Medical Emergency
   h. Endocrinology
   i. Collagen Vascular Disease

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

______________________________________________
Print Name of School Official

______________________________________________
Signature of Chief Academic Officer

_____________________
SS#:

Profession:

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

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.
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

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

PART I: Application Category Information

1. PROFESSION NAME
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 - __________________

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 V: Personal History Information**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<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>
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<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>
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<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>
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<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></td>
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<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>
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<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>
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<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>
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**PART VI: Child Support Information**

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<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>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 &quot;no.&quot;)</td>
<td>Yes</td>
<td>No</td>
</tr>
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</table>

**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.**