

INSTRUCTION SHEET

FOR MAKING APPLICATION UNDER PROVISIONS OF THE ILLINOIS FUNERAL DIRECTORS AND EMBALMERS LICENSING CODE FUNERAL DIRECTOR AND EMBALMER INTERNS

*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, 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 any delay in processing. THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT. All Illinois Funeral Director and Embalmer Intern licenses expire on May 31 of every odd-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**.

NOTE: a) Effective June 1, 1991, all new licenses issued under the Illinois Funeral Director and Embalmer Act shall be combined licenses. Licensed Funeral Director and Embalmer Interns **MUST** accomplish their internship under the supervision of a person who holds a combined Illinois Funeral Director and Embalmer license.

b) **An internship shall not commence prior to official notification from the Division which will provide the issuance date of the Intern License. Only training accomplished on or after the issuance date of the Intern License will be credited toward fulfillment of requirements for permanent licensure.**

c) If your Intern License cannot be renewed and you have not received one year of licensed internship, you must make new application and qualify under the current Act and Rules. **No credit is allowed for examinations previously passed or for training previously earned. Follow all instructions for Licensure Method - Non-Examination** and indicate your previous trainee license number(s) in **PART IV** on 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**.

NOTE: a) Indicate all college/university level coursework in **PART III**, number 6 on the **Application for Licensure and/or Examination**.

b) Indicate Mortuary Science Program in **PART III**, number 7 on the **Application for Licensure and/or Examination**.

c) Do not complete **PART VII** on the **Application for Licensure and/or Examination**.

Step 3. The remainder of this form contains specific instructions for Licensure Method Non-Examination.

NOTE: a) 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, a telephone number for assistance in completing the Application Package is provided on the **REFERENCE SHEET**.

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

FUNERAL DIRECTOR AND EMBALMER INTERN NON-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.*

1. Supporting Document **ED** must be submitted certifying your Associate's degree or Bachelor's degree in mortuary science from an approved mortuary science program. An authorized school official must complete **ED** in its entirety and affix school seal;

or

- a) Official transcripts must be submitted showing proof of successful completion of at least 30 semester (45 quarter) hours of college credit which shall include at least 20 semester (30 quarter) hours of courses in liberal arts, physical, biological, or applied sciences;

and

- b) Supporting Document **ED** must be submitted certifying your graduation from a 12-month course of study in an approved program of mortuary science.
2. Supporting Document **HL** must be completed by a licensed physician attesting that you have been immunized against diphtheria, Hepatitis B and tetanus.
 3. Supporting Document **CA** must be completed by the licensed funeral director and embalmer under whose supervision your internship will be performed. (**SPECIAL NOTE:** Should your sponsor change during your internship, you must notify the Division within 30 days of such change. You must cause a Certificate of Acceptance to be completed by the licensed Funeral Director and Embalmer under whose supervision you will complete the internship. The properly completed form must be returned to you in a sealed envelope. Failure to comply with this requirement will result in an extended period of internship.)
 4. 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 the Illinois Department of Financial and Professional Regulation.
 5. Forward four-page application, supporting documents 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.

Licensure Methods

Definition

Examination

Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.

Endorsement of License

Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.

Acceptance of Examination

Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.

Restoration

Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.

Grandfather/Waiver

Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).

Non-examination

Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.

REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change fees if prevailing circumstances necessitate such action.

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

<u>PROFESSION NAME</u>	<u>PROFESSION CODE</u>	<u>LICENSURE METHOD</u>	<u>APPLICATION FEE</u>
Funeral Director and Embalmer Intern	033	Nonexamination	\$50.00

NOTICE

Successful completion of an examination is not required for issuance of the Funeral Director and Embalmer Intern License. However, the National Conference Examination must be successfully completed prior to the issuance of the Funeral Director and Embalmer license.

For further information regarding the National Conference Examination contact: the International Conference of Funeral Service Examining Boards, Inc., 1885 Shelby Lane, Fayetteville, Arkansas 72704, 479-442-7076, Fax: 479-442-7090, or email: info@theconferenceonline.org .

CHART IV - SCHOOL CODES

**NOT APPLICABLE FOR
FUNERAL DIRECTOR AND EMBALMER INTERNS
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:

1-800-560-6420

TTY - 1-866-325-4949

Please allow 3 weeks from mailing your application before making an inquiry concerning its status.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Funeral Director and Embalmer Interns

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

Before you mail your application, check the following items to make sure your application is complete!

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
ED Form for Associate or Baccalaureate Degree with seal and signature affixed; or Official Transcripts with seal affixed	
ED Form completed by mortuary science college with seal and signature affixed	
Certificate of Health	
CA Form	
Proof of name change (if applicable)	

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

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for double-sided printing.**

APPLICATION FOR LICENSURE AND/OR EXAMINATION

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is **VOLUNTARY**. However, failure to comply may result in this form not being processed.

The following materials are required to make Application for Licensure and/or Examination in Illinois:

1. Four page APPLICATION FOR LICENSURE and/or EXAMINATION.
2. INSTRUCTION SHEET, which gives step by step application instructions for your profession.
3. REFERENCE SHEET, which gives detailed coding information for your profession.
4. SUPPORTING DOCUMENTS, forms, and/or any other documentation you may be required to submit with your application.
5. If the name shown on your supporting documents is different from that shown on your application, you must submit **PROOF OF LEGAL NAME change** - copy of marriage license, divorce decree, affidavit or court order.

Carefully follow all steps outlined on the INSTRUCTION SHEET. In addition, note the following:

- A. Type or print legibly with black ink only.
- B. **FEES ARE NOT REFUNDABLE.**
- C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

A. 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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE \$
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C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

PART II: Applicant Identifying Information--You must notify the Department of Financial and Professional Regulation - Division of Professional Regulation and/or Continental Testing Service in writing, of any address changes after you file this application in order to receive any further information.

1. NAME LAST FIRST MIDDLE		2. TITLE (e.g., M.D., D.D.S., etc.)		3. UNITED STATES SOCIAL SECURITY NO.	
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 <input type="checkbox"/> Female <input type="checkbox"/> Male	
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) _____ -- _____ Home: (____) _____ -- _____ (Area Code) (Area Code) Fax: (____) _____ -- _____ Fax: (____) _____ -- _____ (Area Code) (Area Code)				12. REQUIRED E-MAIL ADDRESS	

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

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

1 2 3 4 5 6 7 8 9 10 11 12 Graduated High School? Yes No Received OR G.E.D.? Yes No

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION ____ / ____ / ____ Month / Year
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5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? Yes No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE		TYPE OF DEGREE EARNED
		FROM	TO	
		Month/Year	Month/Year	

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE		Did You Complete Training?
		FROM	TO	
		Month/Year	Month/Year	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

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.

STATE	PROFESSION NAME	LICENSE NUMBER	DATE OF ISSUANCE	LICENSE STATUS (Active, Lapsed, etc.)
State of Original Licensure				
State of Current Licensure where you most recently have been practicing.				
Other States of Licensure				

(If additional space is needed, attach a separate sheet.)

PART V: Record of Examination

If you have ever taken a licensure examination in Illinois or any other state for the profession for which you are now making application, you must complete the information requested below. EACH EXAMINATION ATTEMPT MUST BE SHOWN. Failure to disclose an examination attempt may result in the denial of your application or other appropriate action.

NAME OF EXAMINATION	STATE	MONTH/YEAR	EXAM RESULTS
			(Passed, Failed, Absent)

(If additional space is needed, attach a separate sheet.)

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

NAME (Last, First, MI):

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

SS#:

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

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

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

Profession:

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

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.

CERTIFICATE OF HEALTH

SUPPORTING DOCUMENT

HL

APPLICANT: Complete the applicant section of this form. The physician who examines you **MUST** hold an active license in the jurisdiction in which he/she practices. Direct the physician to complete the Examining Physician Section of this form and return the completed form to you for inclusion with your Application for Licensure and/or Examination.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH ____/____/____ Month Day Year	3. SOCIAL SECURITY NUMBER ____-____-____
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	_____ Profession Name	_____ Profession Code

EXAMINING PHYSICIAN: Complete the remainder of this form. Reference the above profession name to determine the appropriate statement to check-off. **RETURN THE COMPLETED FORM TO THE APPLICANT.** Physical examination must have occurred within the preceding 12 months.

A. PHYSICIAN NAME FIRST MIDDLE LAST	B. PHYSICIAN LICENSE NUMBER
C. STREET ADDRESS	D. STATE OR TERRITORY OF LICENSURE
E. CITY, STATE, ZIP CODE	F. DATES OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION

STATEMENT I: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

NURSING HOME ADMINISTRATOR

The above-named applicant is of sound physical and mental health.

Yes

No

STATEMENT II: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

FUNERAL DIRECTOR AND EMBALMER

The above-named applicant received the following: 1)Diphtheria-Tetanus (adult type) immunizations Series Booster
2)Hepatitis B Series

I hereby declare that the above information is true and correct.

Signature

Date

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CERTIFICATION OF ACCEPTANCE

SUPPORTING DOCUMENT

CA

APPLICANT: *Complete the applicant section of this form, then forward it to the sponsor(s) who will verify your intern status.*

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 _____ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME		

LICENSED SPONSOR: *Complete the remainder of this form, then return it to the applicant.*

PART I. SPONSOR INFORMATION

A. LICENSED SPONSOR'S NAME	B. BUSINESS/INSTITUTION NAME
B. SPONSOR'S LICENSE NUMBER	D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
E. BUSINESS/INSTITUTION LICENSE NUMBER (If applicable)	F. BUSINESS TELEPHONE NUMBER Area Code (____) ____ - ____

PART II. APPLICANT INTERNSHIP INFORMATION

A. TYPE OF INTERNSHIP <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	B. HOURS PER WEEK	C. BEGINNING DATE ____/____/____ Month Day Year
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I do hereby declare that I am the sponsor of the above-named applicant as indicated.

Licensed Sponsor Signature

Title

Date