

INSTRUCTION SHEET

Physician Assistant Acceptance of Examination Endorsement Restoration

To apply for licensure as a physician assistant in Illinois, read and then follow the directions as they apply to you. This will aid you in accurately completing your application and thus, eliminate any delay in processing. **The application which you submit is valid for 3 years from date of receipt.** All Illinois Physician Assistant licenses expire March 1 of each even-numbered year.

All applicants must complete the 4-page application and submit it with the supporting documents required by the method under which application is being made. You may apply for acceptance of examination, endorsement, or restoration.

4-page Application

Complete the four-page Application for Licensure/Examination as follows:

1. Part I-A, Application Category Information--Select method of application and complete Part I as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Physician Assistant	085	Acceptance of Examination	\$50.00
Physician Assistant	085	Endorsement	\$50.00
Physician Assistant	085	Restoration	**

**See Supporting Document RS for fee amount.

2. Part I-B, Check the box indicating the appropriate information regarding your application.
3. Part II, Applicant Identifying Information--Enter all applicable information requested. You must include your social security number in box 3.
4. Part III, Education Information
 - a. Numbers 1 through 5--Enter all applicable information requested.
 - b. Number 6--Indicate all post secondary education which you have attended since graduation from high school. Please indicate beginning and ending dates by month and year.

Send Application and Supporting Documents to:

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

Fee--Payment must be in the form of a check or money order made payable to:

Department of Financial and Professional Regulation

FEE IS NOT REFUNDABLE.

For Assistance Call:

Department of Financial and Professional Regulation at:
1-800-560-6420

TTY: 1-866-325-4949.

Please allow 45 days from mailing your application before making an inquiry concerning its status.

**4-Page Application
(cont'd)**

5. Part IV, Record of Licensure Information--Indicate in this area whether or not you have ever held a license as a Physician Assistant or a related license. Supporting document CT must also be completed by your original and current jurisdiction of licensure.
6. Part V, Record of Examination--Enter all applicable information requested.
7. Part VI, Personal History Instructions--Must be completed by all applicants.
8. Part VII, Examination Coding Information--Not Applicable.
9. Part VIII, Child Support and Student Loan Information--Must be completed by all applicants.
10. Part IX, Certifying Statement--Read the certifying statement and then sign and date your application.

	Acceptance of Examination / Endorsement	
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If you wish to apply for licensure on the basis of Acceptance of Examination or Endorsement, the following supporting documents must be submitted with the 4-page application and required fee. In order to apply on the basis of Endorsement, you must be currently licensed as a physician assistant in another jurisdiction.

1. Supporting Document CCA **must** be completed and submitted with your application. Your application will not be processed without completion of this form.
2. Submit official transcript, with degree date, verifying successful completion of a physician assistant program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or its predecessor agency.

Transcripts or official letter from the physician assistant program verifying satisfactory completion of a minimum of 45 contact hours in pharmacology is required if you intend to apply for the Mid-Level Practitioner Illinois Controlled Substance license.

3. You must direct the National Commission on Certification of Physician Assistants (NCCPA) to forward **directly** to the Division of Professional Regulation electronically or by mail, evidence of successful completion of the Physician Assistance National Certifying Examination (PANCE), which includes evidence that you are certified by the Commission.
4. **CT (Certification of Licensure)**--Supporting Document CT must be completed by the jurisdiction in which you were first licensed as a physician assistant and from the jurisdiction of current licensure. The completed form may be submitted directly to the Division or returned to you from the licensing entity for inclusion with your application.

Restoration

IMPORTANT NOTICE: These Restoration Instructions apply only to those physician assistants 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 at 1-800-560-6420 for detailed instructions on how to restore it to active status.

1. Supporting Document CCA **must** be completed and submitted with your application. Your application will not be processed without completion of this form.
2. **RS (Restoration of Licensure)**--This form must be completed in its entirety. If this form was not included in the application packet, you must obtain one by contacting the Division of Professional Regulation at 1-800-560-6420.
3. Submit one of the following:
 - If you are currently practicing in another jurisdiction as a physician assistant:
 - a. VE (Verification of Employment/Experience) form completed by your most recent employer verifying current active practice in another jurisdiction; AND
 - b. CT (Certification of Licensure) completed by the jurisdiction where you have most recently been practicing as a physician assistant. The completed form may be submitted directly to the Division or returned to you from the licensing entity for inclusion with your application.
 - If you have not been practicing as a physician assistant:
 - a. Submit proof of current certification directly from the National Commission on the Certification of Physician Assistant (NCCPA); OR
 - b. Copy of your DD214 if restoring within 2-years after active military service.

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.

<u>Licensure Methods</u>	<u>Definition</u>
Examination	Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.
Endorsement of License	Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.
Acceptance of Examination	Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.
Restoration	Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.
Grandfather/Waiver	Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).
Non-examination	Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.

IMPORTANT NOTICE

Elder and Child Abuse Reporting

"Pursuant to Public Act 91-0244, effective January 1, 2000, if you have reason to believe that an adult 60 years of age or older who resides in a domestic living situation who, because of dysfunction is unable to seek assistance for himself or herself has, within the previous 12 months been subject to abuse, neglect or financial exploitation, the mandated reporter shall, within 24 hours after developing such belief, report this suspicion to the Department on Aging. Reports should be made to **DEPARTMENT ON AGING AT 1-800-252-8966.**"

"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.**"

**Illinois Department of Financial and Professional Regulation
Division of Professional Regulation**

Application Checklist for Physician Assistants

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	
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 from original jurisdiction of licensure and current jurisdiction of practice.	
Official transcript from approved physician assistant program with degree and date conferred.	
Proof of passage of examination and valid certification from NCCPA	
RS Form (restoration method only)	
VE Form (restoration method only)	

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

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Received OR G.E.D.?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION _____ / _____ Year		
5. COLLEGE OR UNIVERSITY (Circle number of years completed)				
1 2 3 4 5 6 7 8	Graduated? <input type="checkbox"/> Yes <input type="checkbox"/> 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
				<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.)

PART VI: Personal History Information <i>(This part must be completed by all applicants)</i>	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

PART VII: Child Support and Tax Information (Every applicant is required by law to respond to the following questions)
<p>1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</p> <p>Are you more than 30 days delinquent in complying with a child support order? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>(NOTE: If you are not subject to a child support order, answer "no.")</i></p>
<p>2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."</p> <p>Are you delinquent in the filing of state taxes? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

PART VIII: Certifying Statement
<p>Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.</p> <p>_____</p> <p style="text-align: center;">Signature of Applicant</p> <p>_____</p> <p style="text-align: center;">Date</p> <p>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.</p>

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

HEALTH CARE WORKERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

3. PROFESSIONAL LICENSE NUMBER (if any)
_____ - _____

2. ADDRESS STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER
_____ - _____ - _____

Pursuant to 20ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding convictions pertaining to certain offenses. **Please check applicable profession.**

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

Any other license issued by the Department under the Acts listed in this Section and the Controlled Substances Act [740 ILCS 40], except for pharmacy technicians, issued to a person subject to the Code and this Part.

In order for your application to be evaluated, you must respond to each of the following questions:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? * | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? * | <input type="checkbox"/> | <input type="checkbox"/> |

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

Certification Statement

Under penalties of perjury, I declare that I have examined this Form and all supporting documents and/or information submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Email

Date

* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- A. Is there now or has there ever been any formal action commenced against the applicant? Yes No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? **(If yes, attach a certified copy of disciplinary action.)** Yes No

PART V - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

S E A L		Print Name		Signature
		Title		Date
		Agency/Board Street Address		Area Code ()
		City, State, ZIP Code		Telephone Number

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

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

PHYSICIAN ASSISTANT NOTICE OF WRITTEN COLLABORATIVE AGREEMENT

COLLABORATING PHYSICIAN: Complete and submit this form as official notification that you have entered into a written collaborative agreement with a physician assistant under the Physician Assistant Practice Act of 1987 (225 ILCS 95/). All forms must be typed or legibly printed in ink. The physician assistant listed below shall not perform any tasks or duties delegated by the collaborating physician until this form is completed and submitted to the Division.

Completed forms may be submitted to the Division as follows: Email form to FPR.MedicalUnit@illinois.gov; Fax form to 217-524-2169; or Mail form to IDFP - Division of Professional Regulation, 320 West Washington, 3rd Floor, Springfield, Illinois 62786.

Submitted forms will be processed by the Division in the order in which they are received. It may take at least 4-6 weeks for a submitted form to be processed by the Division. After the form is processed, the Division will email or fax an acknowledgment letter to the collaborating physician. The acknowledgment letter must be maintained by the collaborating physician along with the signed, written collaborative agreement. The collaborating physician shall provide a copy of such documentation to the Division upon request.

If the written collaborative agreement is terminated, the collaborating physician must, within 10 days of termination, complete and submit to the Division a NOTICE OF TERMINATION OF COLLABORATION form.

A written collaborative agreement is required for all physician assistants to practice in Illinois, except for physician assistants in hospitals, hospital affiliates, or ambulatory surgical treatment centers as set forth in Section 7.7 of the Physician Assistant Practice Act.

For physician assistants employed by a practice group or other entity employing multiple physicians, one of the physicians practicing at a location shall be designated the collaborating physician. The other physicians with the practice group or other entity who practice in the same general type of practice or specialty as the collaborating physician may collaborate with the physician assistant with respect to their patients.

Forms are periodically updated. To ensure that you are using the current form, visit the IDFP website at www.idfp.com/profs/Physician-Assistant.asp.

COLLABORATING PHYSICIAN INFORMATION

1. COLLABORATING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036- _____ 336- _____	3. DATE AGREEMENT WILL BEGIN ____ / ____ / ____
4. ILLINOIS PRACTICE ADDRESS (Street, City, State, Zip Code)	5. ILLINOIS PHONE NUMBER OF PRACTICE (Include Area Code) () _____	
	6. ILLINOIS MEDICAL STAFF/CREDENTIALING OR PHYSICIAN Fax: () _____ Email: _____	

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT	2. ILLINOIS LICENSE NUMBERS 085- _____ 385- _____	3. EMPLOYMENT STATUS (See Below) <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME
4. CONTACT INFORMATION FOR PHYSICIAN ASSISTANT HOME/CELL TELEPHONE () _____ PERSONAL EMAIL REQUIRED _____ SIGNATURE _____		

The Physician Assistant Practice Act allows a collaborating physician to collaborate with a maximum of 7 full-time equivalent physician assistants. "Full-time equivalent" means the equivalent of 40 hours per week per individual. You must indicate the number of full-time physician assistants and part time physician assistants you currently have collaborative agreements with, including the physician assistant listed above.

Full-time physician assistants _____ Part-time physician assistants _____

Signature of Collaborating Physician _____ Date Signed _____

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is guilty of a Class A misdemeanor.

Notice of Delegated Authority for Prescription Drugs

PHA-RX

No formal application or fee is required if a supervising physician is delegating authority to prescribe and/or dispense prescriptive drugs which are not categorized as Schedule II, III, IV, V, as defined in Article II of the Illinois Controlled Substances Act. The NOTICE OF SUPERVISORY CONTROL and the delegation form must be submitted prior to authority being processed. A license for prescription drugs only is not issued.

SUPERVISING PHYSICIAN OF RECORD: Complete this form as official notification you are delegating limited prescriptive drug authority to the physician assistant named herein. Mail forms to:

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

Should you cease supervisory control and/or terminate delegated prescriptive authority, you must notify the Division within **10** days of termination by completing the NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED PRESCRIPTIVE AUTHORITY.

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms. **Please allow 4-6 weeks for processing of new applications and changes in supervision and/or delegation.**

1. NAME OF PHYSICIAN ASSISTANT (Last, First, Middle Initial)	2. DATE OF BIRTH ____ / ____ / ____ Month Day Year	3. SOCIAL SECURITY NUMBER ____ - ____ - ____
4. HOME ADDRESS STREET, CITY, STATE, ZIP CODE	5. MAIDEN OR GIVEN SURNAME	
	6. TELEPHONE NUMBER () _____	
	7. LICENSE NUMBER OF PHYSICIAN ASSISTANT 085 - _____	

This is to certify I am the supervising physician and have delegated limited prescriptive authority to my physician assistant, _____, to prescribe and/or dispense prescriptive drugs which are not categorized as Schedule II, III, IV, V, as defined in Article II of the Illinois Controlled Substances Act.
(Printed name of physician assistant)

I further certify the delegation of prescriptive authority is appropriate to my practice and within the scope of the physician assistant's training. The delegated prescriptive authority guidelines will be outlined and maintained, along with the acknowledgment letter in the physician assistant's written supervisory agreement.

_____ Printed Name of Delegating Physician	036- _____	336- _____
_____ Signature of Delegating Physician	_____ Date Signed	
_____ Date of Delegated Prescriptive Authority		

IMPORTANT NOTICE: Completion of this form is required by 225 ILCS 95/1, et.seq. of the Illinois Compiled Statutes. Disclosure of this information is mandatory. Any person who is found to have knowingly violated any provision of this Act is subject to discipline under the Act.

Notice of Termination of Supervision and/or Delegated Authority (Physician Assistant)

SUPERVISING PHYSICIAN: If you cease supervisory control of physician assistant on your record, you are required to submit the **NOTICE OF TERMINATION OF SUPERVISION AND/OR DELEGATED AUTHORITY** within **10** days of termination.

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

All forms must be typed or legibility printed in black ink. Forms are periodically updated. Visit the IDFPR Web site at www.idfpr.com to ensure you are using the current forms. **Please allow 4-6 weeks from receipt for processing.**

PHYSICIAN ASSISTANT INFORMATION

1. NAME OF PHYSICIAN ASSISTANT	2. ILLINOIS LICENSE NUMBERS 085-_____ 385-_____
3. CONTACT NUMBER FOR PHYSICIAN ASSISTANT () _____	4. EMAIL _____

Signature _____

PRIMARY SUPERVISING PHYSICIAN INFORMATION

1. SUPERVISING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. PRACTICE ADDRESS (Street, City, State, Zip Code)	4. PHONE NUMBER OF PRACTICE (Include Area Code) () _____
	5. MEDICAL STAFF/CREDENTIALING FAX () _____

Date Supervisory Control and Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Primary Supervising Physician: _____ Date Signed _____

COMPLETE THIS SECTION IF YOU ARE TERMINATING DELEGATED PRESCRIPTIVE AUTHORITY BUT WILL CONTINUE SUPERVISORY CONTROL OF THE PHYSICIAN ASSISTANT NAMED ABOVE

1. SUPERVISING PHYSICIAN NAME	2. ILLINOIS LICENSE NUMBERS 036-_____ 336-_____
3. PRACTICE ADDRESS (Street, City, State, Zip Code)	4. PHONE NUMBER OF PRACTICE (Include Area Code) () _____
	5. MEDICAL STAFF/CREDENTIALING FAX () _____

Date Delegated Prescriptive Authority was Terminated: _____
Month - Day - Year

Signature of Supervising Physician: _____ Date Signed _____

INFORMATION SHEET FOR MID-LEVEL PRACTITIONER PRESCRIPTIVE AUTHORITY

A mid-level practitioner controlled substance license (385/CS) may be issued to a physician assistant (PA) whose supervising physician of record has delegated limited prescriptive authority for controlled substance Schedules II, III, IV, V. The physician is required to include and maintain the guidelines for the delegated authority in the written supervisory agreement. Copies of the acknowledgement letter from the Division, 385/CS and Federal DEA licenses are to be kept with the supervisory agreement. Agreements are not to be submitted with this application; however they should be available upon request of the Division of Professional Regulation.

- Application must be fully completed and submitted with the required fee and the delegation form PHA-CS. Prescriptive authority for Schedules is **not** effective until the 385/CS license has been issued.
- When Division records are updated, the acknowledgment letter with effective dates will be faxed to the physician. Letters are not mailed. To ensure receipt, the fax number listed on supervision notice should be for a medical staff, credentialing, or similar office located within the practice location. The letter is to be maintained with the written supervisory agreement.
- If a physician ceases supervisory control or wishes to terminate delegated prescriptive authority, the termination form must be completed within **10** days of termination. It is the responsibility of the physician to submit the termination form to ensure their record is updated.
- If the PA is supervised by more than one physician at a different location or in a different specialty, separate supervision and delegation forms shall be submitted by each physician delegating authority. A PA should only hold one 385/CS license for the purposes of prescribing at multiple locations.
- PA's holding active 085/PA and 385/CS licenses, who are changing employment and/or delegated prescriptive authority, may fax updated employment and delegation forms to (217) 524-2169. The signed originals must be mailed.
- Prescriptive authority does **NOT** transfer from one physician to another physician. If a PA changes supervising physicians, updated employment and delegation forms must be submitted.
- PHA-CS forms without Schedules marked will not be processed and will result in delayed issuance.
- The supervision notice must be on file before any delegation forms will be processed. Prescriptive authority may not be delegated by alternate supervising physicians.
- For practice groups or other entities employing multiple physicians, one of the physicians at that location may be designated as the supervising physician. The other physicians, who practice the same general type of medicine or specialty as the supervising physician, may supervise the PA with respect to their own patients without being deemed alternate supervising physicians as defined by the PA Practice Act. All designated physicians must be listed and maintained with the written guidelines.
- If the PA is to be delegated authority for Schedule II drugs, evidence of completion of at least 45 graduate contact hours in pharmacology from a program accredited by the ARC-PA or its successor agency is required.
- PA's will be required to complete annually at least five (5) hours of continuing education in pharmacology verified at the time of renewal.
- The supervising physician may only delegate controlled substances that s/he prescribes.
- All forms must be typed or legibility printed in black ink. Application and forms are periodically updated. Visit the IDFPFPR Web site at www.idfpr.com to ensure you are using the current forms.
- **Please allow 4-6 weeks for processing of new applications and changes in delegation.**

APPLICATION FOR MID-LEVEL PRACTITIONER CONTROLLED SUBSTANCE LICENSE

******READ AND FOLLOW INSTRUCTIONS CAREFULLY****
FAILURE TO DO SO WILL DELAY ISSUANCE!**

The *Mid-Level Practitioner Controlled Substance License (385/CS)* application and fee may be submitted when applying for the physician assistant license (085/PA). **FEES ARE NOT REFUNDABLE.** Failure to properly complete the application or submit the required fee will delay licensure. Normal processing time is 4-6 weeks after the Division receives the application and/or forms during non-peak times. Submit the completed application and required fee to:

IDFPR - Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786

APPLICATION COMPLETION GUIDE

PART II - APPLICANT IDENTIFYING INFORMATION

- Name, address, Social Security number, maiden or given surname listed
- Indicate the Illinois address where the 385/CS license is to be issued, including department or suite number.
- Applicant's contact number and email address.

PART III- PERSONAL HISTORY INFORMATION

- If you answer affirmatively to any question, additional documentation and review will be required. Submit a detailed statement and applicable documentation for any affirmative response.

PART IV – CHILD SUPPORT and/or STUDENT LOAN INFORMATION

- If you answer affirmatively to either question, additional documentation and review will be required. Submit a detailed statement and applicable documentation for any affirmative response.

PART V – CERTIFYING STATEMENT

- Original signature and date are required

FORMS COMPLETION GUIDE

CCA FORM

- Required from all health care workers. If you submitted the 385/CS application with your 085/PA application, only one CCA form is required.

PHYSICIAN ASSISTANT – NOTICE OF SUPERVISORY CONTROL

- Form must be submitted or updated before the 385/CS license will be issued.
- Fax number to medical staff, credentialing or similar office where the acknowledgment will be faxed in order to expedite credentialing.

NOTICE OF DELEGATED AUTHORITY FOR PRESCRIPTION DRUGS AND CONTROLLED SUBSTANCES (PHA-CS)

- Supervising physician must indicate the Schedules delegated to the PA, provide their Illinois Controlled Substance License Number (336), list the date of delegation*, sign and date. Failure to mark the Schedules to be delegated will delay issuance.
- The PHA-CS form also includes non-controlled substance prescription drugs not categorized as schedule drugs (formally Legend Drugs).

***SCHEDULE AUTHORITY IS NOT EFFECTIVE UNTIL THE MID-LEVEL LICENSE IS ISSUED.**

NOTICE OF TERMINATION OF SUPERVISION and/or DELEGATED AUTHORITY

- When supervisory control and/or prescriptive authority is terminated, the supervising physician is required to submit the termination form **within 10 days** of termination. It is the responsibility of the supervising physician to submit the termination form in order to remove the physician assistant from Division records.

**APPLICATION FOR
PHYSICIAN ASSISTANT MID-LEVEL PRACTITIONER
ILLINOIS CONTROLLED SUBSTANCES LICENSE**

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/301, et.seq. of the 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.

1. A physician assistant may only prescribe or dispense prescriptions or orders for drugs and medical supplies within the scope of practice of the supervising physician who has submitted Supervision and Delegation Forms.
2. An Illinois Physician Assistant Mid-Level Practitioner Controlled Substances License is a prerequisite to a Federal Mid-Level Practitioner Controlled Substances Registration (DEA).
3. A physician assistant may only hold **ONE** Controlled Substance License

- A. Type or print legibly with black ink only.
- B. The fee is \$5 - Make check payable to the Department of Financial and Professional Regulation. **THIS FEE IS 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.

Submit application and fee to: Department of Financial and Professional Regulation
 Division of Professional Regulation
 320 West Washington, 3rd Floor
 Springfield, Illinois 62786

PART I: Application Category Information

1. PROFESSION NAME Physician Assistant Mid-Level Practitioner Controlled Substances License	2. PROFESSION CODE 385	3. LICENSURE METHOD Non-examination	4. FEE \$5
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PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE	2. TITLE PA-C	3. ILLINOIS PHYSICIAN ASSISTANT LICENSE NO. 085	4. UNITED STATES SOCIAL SECURITY NO. ____ - ____ - ____
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5. PERMANENT MAILING ADDRESS STREET	CITY	STATE/COUNTRY	ZIP CODE	COUNTY
+ _____				

6. LOCATION (STREET/CITY/ZIP CODE)
WHERE CONTROLLED SUBSTANCES LICENSE IS TO BE ISSUED.

FACILITY _____

STREET _____

CITY _____

IL _____ + _____

7. MAIDEN OR GIVEN SURNAME _____

8. CONTACT INFORMATION

Home/Cell (____) _____ - _____
Area Code

Email _____

Medical Staff/Credentialing Office Fax
(____) _____ - _____
Area Code

PART III: Personal History Information <i>(This part must be completed by all Applicants)</i>	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. Have you been denied a professional license or permit or privilege of taking an examination, or had a professional license or permit ever disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
4. Do you have any disease or condition that interferes with 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, that presently interferes with your ability to practice your profession? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Has any previous registration held by you under the Illinois Controlled Substances Act been surrendered, suspended, revoked, denied, placed on probation, or is pending action? <i>If yes, attach a detailed statement for each action, including dates and place of incident, and the nature of the offense.</i>		

PART IV: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)

<p>1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.</p> <p>Are you more than 30 days delinquent in complying with a child support order? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>(NOTE: If you are not subject to a child support order, answer "no.")</i></p>
<p>2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)</p> <p>Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes <input type="checkbox"/> No <input type="checkbox"/></p>

PART V: Certifying Statement

I hereby apply for an Illinois Physician Assistant Mid-level Practitioner Controlled Substances License 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 THE FEE IS 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.***

