INSTRUCTION SHEET

Marriage and Family Therapy

- **Examination**
  Acceptance of Examination
  Endorsement of Licensure
  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.

As a condition of licensure as an Illinois Marriage and Family Therapist, you must first meet the educational and experience requirements as defined by the Rules for the Administration of the Marriage and Family Therapy Licensing Act, Sections 1283.15, 1283.20, 1283.25, and 1283.30. If you have met these requirements, you may apply for licensure by following the applicable instructions starting on page 3.

EXPERIENCE/EDUCATION REQUIREMENTS

Professional Work Experience

An applicant for a license as a marriage and family therapist shall, following receipt of the first qualifying education degree, complete at least 3000 hours of professional work experience in not less than a 2 year period.

a) Professional work experience is defined as providing professional services, including clinical activities as defined in the section on clinical experience as well as non-clinical activities related to the practice of the profession of marriage and family therapy. Following receipt of the first qualifying education degree, at least 3000 hours of professional work experience is required, which includes 1000 hours as defined in the Clinical Experience section and 200 hours of clinical supervision as defined in the Clinical Supervision section.

b) Professional work experience shall be obtained in not less than 2 years and no more than 5 years.

(Source: Added at 22 Ill. Ref. 16482, effective September 3, 1998)

Clinical Experience

An applicant for a license as a marriage and family therapist shall, following receipt of the first qualifying education degree, complete at least 1000 hours of face-to-face client contact with individuals, couples and families for the purpose of evaluation and treatment of mental, emotional, behavioral and interpersonal disorders and psychopathology. At least 350 hours of the 1000 hours of face-to-face client contact must involve working with only one client present in therapy sessions, and at least 350 hours of the 1000 hours of face-to-face client contact must involve conjoint therapy, i.e. working with two or more clients present in therapy sessions who are in significant relationships with each other outside the therapy context. The applicant shall be supervised as defined in the Clinical Supervision section during the whole period the applicant is accumulating clinical experience.

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

Clinical Experience (cont'd)

Clinical experience in the practice of marriage and family therapy may be gained by providing treatment as defined in the Professional Work Experience section.

Clinical Supervision

An applicant must complete 200 hours of clinical supervision of marriage and family therapy. At least 100 of these 200 clinical supervision hours must occur following the receipt of the first qualifying degree. Up to 100 hours of clinical supervision accumulated during graduate training may be counted toward the required 200 hours of clinical supervision. At least 100 of the 200 hours of clinical supervision must be completed with a marriage and family therapy supervisor who has met requirements set forth in Section 1283.25.

Education

An applicant for a license as a marriage and family therapist shall hold one of the following:

1) A master's or doctoral degree in marriage and family therapy from a regionally accredited educational institution;

2) A master's or doctoral degree from a regionally accredited educational institution (by the U.S. Office of Education) in a related field (i.e., behavioral science or mental health) with an equivalent course of study in marriage and family therapy as set forth in subsection (b) of Section 1203.30; or

3) A master's or doctoral degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education of the American Association for Marriage and Family Therapy.

Prior to or on December 31, 1999, an applicant must have completed a minimum of 36 semester hours or 48 quarter hours of graduate coursework. Beginning January 1, 2000, an applicant must have completed a minimum of 48 semester hours or equivalent hours of graduate coursework. The applicant's graduate coursework, at a minimum, shall be substantially equivalent to the curriculum listed in Section 1283.30.

LICENSURE APPLICATION INSTRUCTIONS

To apply under the provisions of the Illinois Marriage and Family Therapy Licensing Act, read and follow each of the steps below in the order they are listed. 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.** Licenses issued under the Marriage and Family Therapy Licensing Act expire on February 28 of each odd-numbered year.

Step 1--Application

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

IMPORTANT NOTE! READ THIS NOW.

Refer to the attached Licensure Methods and Definitions page to determine your specific licensure method.

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
Marriage & Family Therapist	166	Examination (To be taken)	*
Marriage & Family Therapist	166	Acceptance of Examination (Has been taken)	*
Marriage & Family Therapist	166	Endorsement of Licensure	*
Marriage & Family Therapist	166	Restoration	**

*See attached Reference Sheet for fee amount.

See **RS form 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.

4. Part III, Education Information

   a. Numbers 1 through 5--Enter all applicable information requested.
   b. Number 6--Indicate undergraduate, graduate and post-graduate education when completing this part of the application.

5. Part IV, Record of Licensure Information--Indicate in this area whether or not you have ever held a license as a marriage and family therapist, or a related license. Supporting document **CT** must also be completed by the jurisdiction of original licensure and the jurisdiction where you have most recently been practicing.

6. Part V, Record of Examination--Must be completed by all applicants.

7. Part VI, Personal History Instructions--Must be completed by all applicants.

8. Part VII, Examination Coding Information--Do not complete this portion of the application.

9. Part VIII, Child Support and/or 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.

Step 2--Supporting Documents

IMPORTANT NOTE!
READ THIS NOW.

The following instructions, Steps 2, 3, and 4, pertain only when applying for licensure under Examination, Acceptance of Examination, or Endorsement of License.

If you wish to RESTORE your inactive license, go to page 9 of these instructions.

You may qualify for licensure under one of the following application methods: Examination, Acceptance of Examination, or Endorsement of License. The method of application under which you are applying determines the documentation which must be submitted with the four-page application.

All documents submitted in a foreign language must be accompanied by an original official, 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.

If you submit original or official documents that you want returned to you, you must also provide a photocopy of the document(s) and a self-addressed stamped envelope.

Selecting correct forms to complete: Refer to the tables below in deciding which supporting documents must be submitted along with the four-page application.

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

Application Method	Required Supporting Documents
Examination	
If you are a Clinical Member of the American Association for Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ Membership Certification
If you graduated from an Illinois Department of Financial and Professional Regulation Approved Comprehensive Program in Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT (Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor) ❑ ED
All others	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT (Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor) ❑ ACW-MFT ❑ ED ❑ Transcript

Application Method	Required Supporting Documents
Acceptance of Examination	
If you are a Clinical Member of the American Association for Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ Membership Certification ❑ Examination Scores from PES
If you graduated from an Illinois Department of Financial and Professional Regulation Approved Comprehensive Program in Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT(Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor) ❑ ED ❑ Examination Scores from PES
All others	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT (Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor ❑ ACW-MFT ❑ ED ❑ Transcript ❑ Examination Scores from PES
Endorsement of License	
If you are a Clinical Member of the American Association for Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ Membership Certification ❑ CT ❑ Examination Scores from PES
If you graduated from an Illinois Department of Financial Professional Regulation Approved Comprehensive Program in Marriage and Family Therapy	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT (Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor) ❑ ED ❑ CT ❑ Examination Scores from PES
All Others	❑ 4-page Application ❑ CCA ❑ PCE-MFT ❑ VSE-MFT (Self-employed only) ❑ CSW-MFT ❑ SR-MFT (One per supervisor) ❑ ACW-MFT ❑ ED ❑ Transcript ❑ CT ❑ Examination Scores from PES

Step 3--Fill Out Supporting Documents

Fill out the correct Supporting Documents which are listed in the table you selected during Step 2. Below are the specific instructions for each form. Read all the instructions for the form you are completing before beginning. If you need more than one copy of any of the forms, you are authorized to use a photocopy as necessary.

Definitions:

"First qualifying degree" is the first graduate degree during which you completed the majority of the coursework you are using toward this license. For more specifics, see the LMFT Requirements, Section 1283.30(a).

"Individual Therapy" means face-to-face client contact working with only one client present in a therapy session.

"Conjoint Therapy" means face-to-face client contact working with two or more clients present in a therapy session who are in significant relationships with each other outside the therapy context. Therefore individual and group therapy experience do not count as conjoint therapy.

Supporting Documents:

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. **PCE-MFT (Professional/Clinical Experience)**--This form is used to evaluate your Professional Work Experience and your Clinical Experience. List only places you worked toward completing Professional Work and Clinical Experience requirements.

   In evaluating your Clinical Experience, the Board requires that you specify the total number of face-to-face client contact hours (i.e. the total of your individual and conjoint therapy hours), the number of total Clinical Experience hours during which you were providing individual therapy, and the number of total Clinical Experience hours during which you were providing conjoint therapy. Also note that at the end of each **PCE-MFT** form is a place to enter the Grand Totals for each form. Please calculate and fill in.

   Note that if you are a Clinical Member of the American Association for Marriage and Family Therapy, you are not required to complete this form.
3. **VSE-MFT (Verification of Self-Employment/Experience)**-- This document must be completed only if part of your work history included a period of self-employment as a therapist and you are not a Clinical Member of the American Association for Marriage and Family Therapy. This form must be completed by three (3) peers, clients, or colleagues who are familiar with your work. This form, in combination with the **PCE-MFT**, is used to evaluate your Professional Work Experience and your Clinical Experience.

4. **CSW-MFT (Clinical Supervision Worksheet)**--This document must be completed by all applicants who are not a Clinical Member of the American Association for Marriage and Family Therapy. This form, in combination with the **SR-MFT**, is used to evaluate your Clinical Supervision.

   Note that a **SR-MFT** form should be completed for each supervisory experience listed on form **CSW-MFT.** If you are unclear about whether a supervisor qualifies as a marriage and family therapy **(MFT)** supervisor or as a mental health (MH) supervisor, ask the supervisor to complete part H of the **SR-MFT** form.

   If you had clinical supervision with the same supervisor both prior to and after completion of your first qualifying degree, list this supervisor twice on form **CSW-MFT** and give the supervisor two (2) **SR-MFT** forms to complete, one for the supervision that took place prior to graduation and one for the supervision that took place after graduation.

   Note, at the end of each **CSW-MFT** which you submit, sum up your hours across all supervisors included on that form. Please fill in the grand totals for this form in the appropriate box.

5. **SR-MFT (Supervisor's Report)**--This document must be completed by each supervisor listed on form **CSW-MFT**. This form, in combination with the **CSW-MFT**, is used to evaluate your Clinical Supervision.

   The applicant should complete Sections 1 to 10 and forward the form to each supervisor for completion. The supervisor should complete Parts I and II. If the applicant had clinical supervision with the same supervisor both prior to and after completion of your first qualifying degree, then this supervisor should be listed twice on form **CSW-MFT** and be given two (2) **SR-MFT** forms to complete, one for the supervision that took place prior to graduation and one for the supervision that took place after graduation.

6. **ACW-MFT (Academic Coursework and Practicum)**--This document must be completed by all applicants except those who are clinical members of the American Association for Marriage and Family Therapy or those who graduated from an Approved Comprehensive Program in Marriage and Family Therapy.

7. **Approved Comprehensive Program in Marriage and Family Therapy**-If you graduated from an Illinois Department of Financial and Professional Regulation Approved Comprehensive Program in Marriage and Family Therapy in accordance with Section 1283.30, please make that clear on the **ED** form. You are not required to complete form **ACW-MFT**.

8. **ED (Certification of Education)**--This document must be completed for all applicants who are not a Clinical Member of the American Association for Marriage and Family Therapy. This form, in combination with the **ACW-MFT** form and your transcript, is used to evaluate your Education.

The applicant should complete the top section and have the form completed by an official of the college or university from which your master's or doctoral degree was received and **have the School Seal affixed**. It is suggested that you request the chair of the program in which your degree was conferred to complete this document. If your program was an Illinois Department of Financial and Professional Regulation Approved Comprehensive Program in Marriage and Family Therapy in accordance with Section 1283.30, this should be indicated on this form.

9. **Transcript**--Submit an official transcript from a master's or doctoral degree of a college and/or professional institution **with the School Seal affixed**. The transcript, in combination with the **ACW-MFT** and **ED**, is used to evaluate your education.

10. **Membership Certification**--In lieu of Supporting Documents **PCE-MFT, VSE-MFT, CSW-MFT**, **SR-MFT**, **ACW-MFT**, and **ED**, the Department will accept certification of active Clinical Membership in the American Association for Marriage and Family Therapy. Please submit evidence of active Clinical Membership to the Department of Financial and Professional Regulation.

11. **CT (Certification of Licensure)**--This document must be completed for applicants who have ever held a license as a marriage and family therapist in any jurisdiction. Complete the top portion of the form and forward the form to the jurisdiction of original licensure and/or the jurisdiction where you have most recently been practicing. You must direct the licensing agency/board to return completed form **CT** directly to you.

12. **Examination Scores**--If you have previously taken the Association of Marital and Family Regulatory Board's (AMFTRB) Examination in Marriage and Family Therapy, instruct the Interstate Reporting Service, telephone number 212-367-4341, to forward your scores directly to you.

Step 4 - Send Complete Package to the Department

You should keep a copy of the completed application for your records. If any questions come up about your application, you have a reference.

Send Application and all Supporting Documents to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7007, HSS-4
Springfield, IL 62791

Send the appropriate fee from Reference Sheet A. Payment must be in the form of a check or money order made payable to:

Department of Financial and Professional Regulation

For assistance call one of the following numbers and state that you are applying to become licensed as a marriage and family therapist and need help with your application.

1-800-560-6420
TTY - 1-866-325-4949

Application for licensure by examination is a dual application process. Your application for examination will be evaluated by the Marriage and Family Therapy Licensing and Disciplinary Board to determine your eligibility for examination. Once your application has been evaluated, the Department will notify you of the results of the evaluation. If it is determined that you are eligible for examination, included in the Department's notification will be an examination registration form and further instructions.

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

RESTORATION

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

~IMPORTANT NOTICE~

These Restoration Instructions apply only to those marriage and family therapists whose licenses have been on inactive status, or in non-renewed status, for five or more years.

If your license has been inactive, or in non-renewed status, for less than five years, you should contact the Department of Financial and Professional Regulation at 1-800-560-6420 for detailed instructions on how to restore it to active status.

To restore your Illinois Marriage and Family Therapist license which has been expired for more than five years, the following documents must be submitted.

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

2. Complete four-page Application for Licensure/Examination. See instructions on page 3.

3. Supporting Document **CT** must be completed by the jurisdiction of current licensure where you have most recently been practicing. You must direct the licensing agency/board to return completed form **CT** directly to the address indicated in number 10 below.

4. Supporting Document **RS** must be completed. (If this form was not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 1-800-560-6420.)

5. If restoring after active military service, submit a copy of DD214.

6. 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.

Restoration (cont'd)

7. If you are unable to submit supporting document **VE** or form DD214, submit proof of passage of the AMFTRB examination during the period the registration was lapsed or on inactive status.

8. All applicants for Restoration of Marriage and Family Therapist license in Illinois must submit proof of having met the 30-hour requirement of approved continuing education.

9. 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.

10. 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.

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 - A

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change examination dates, filing deadlines and fees if prevailing circumstances necessitate such action.

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

PROFESSION NAME	PROFESSION CODE	LICENSURE METHOD	APPLICATION FEE
Marriage & Family Therapist	166	Examination	$100.00
Marriage & Family Therapist	166	Acceptance of Exam	$100.00
Marriage & Family Therapist	166	Endorsement of License	$200.00
Marriage & Family Therapist	166	Restoration	See Supporting Document RS

CHART II - EXAMINATION / APPLICATION

NOTE: SINCE THIS APPLICATION FOR EXAMINATION IS A DUAL PROCESS YOU MUST:

- **STEP 1: Complete the Department's licensure application and submit it to the Department.**
- **STEP 2: Once your application has been approved by the Department, you will be notified by a letter from the Department including instructions on how to register with:**

  Continental Testing Service, and
  Association of Marital and Family Therapy Regulatory Boards

CHART III - EXAMINATION DATES

Examinations are administered monthly. Please contact Continental Testing Services, Inc. to determine final filing dates. Department approval is required prior to applying with Continental Testing Services.

CHART IV - SCHOOL CODES

NOT APPLICABLE FOR LICENSED MARRIAGE & FAMILY THERAPIST

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:

Licensure Methods **Except** Examination **(US ONLY)**	Examination Licensure Method **Only**
1-800-560-6420 TTY 1-866-325-4949 Please allow 6 weeks from mailing your application before making an inquiry concerning its status.	708/354-9911

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Marriage & Family Therapist

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**
Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.	
ED Form	
Membership Certification (Clinical Member of AAMFT) (if applicable)	
PCE-MFT Form (if applicable)	
VSE-MFT Form (if applicable)	
CSW-MFT Form (if applicable)	
SR-MFT Form (if applicable)	
ACW-MFT Form (if applicable)	
Official Transcript (if applicable)	
Examination Scores (if applicable)	
CT Form from ***original*** state of licensure and ***current*** state of licensure (if applicable)	
RS Form (if applicable) (**NOTE**: if restoring)	
Proof of 30 hours of Approved Continuing Education (if applicable)	
Copy of **DD214** if restoring from active military service	

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

C. Disclosure of your U.S. social security number, if you have one, is mandatory, in accordance with 5 Illinois Compiled Statutes 100/10-65 to obtain a license. The social security number may be provided to the Illinois Department of Public Aid to identify persons who are more than 30 days delinquent in complying with a child support order, or to the Illinois Department of Revenue to identify persons who have failed to file a tax return, pay tax, penalty or interest shown in a filed return, or to pay any final assessment or tax penalty or interest, as required by any tax Act administered by the Illinois Department of Revenue, or to other entities for verification of identification.

PART I: Application Category Information

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

1. PROFESSION NAME	2. PROFESSION CODE	3. LICENSURE METHOD	4. FEE
	___ ___ ___		$

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- ☐ This is the first time I have made application for this profession in Illinois.
- ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
- ☐ Other: _____
- ☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.
- ☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

PART 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	10. AGE
	___ ___ / ___ ___ / ___ ___ ___ ___ (Month / Day / Year)	____ ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (Area Code)

Home: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (Area Code)

Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (Area Code)

Fax: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS

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

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

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

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

2. NAME OF LAST PRELIMINARY SCHOOL ATTENDED	3. LAST PRELIMINARY SCHOOL LOCATION (City and State)	4. DATE OF GRADUATION ___ ___ / ___ ___ ___ ___ Month Year

5. COLLEGE OR UNIVERSITY (Circle number of years completed)

1 2 3 4 5 6 7 8 Graduated? ☐ Yes ☐ No

6. COLLEGE OR UNIVERSITY NAME (Undergraduate and Graduate)	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	TYPE OF DEGREE EARNED
		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 FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
		Month/Year	Month/Year	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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 *(This part must be completed by all applicants)*	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *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.*		
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: Examination Coding Information *(This part is for examination applicants only)*

Refer to the REFERENCE SHEET enclosed with this application package and complete the following:

a) CHART II - Select examination(s) you desire and enter Test Codes. ☐☐ ☐☐ ☐☐ ☐☐ ☐☐ ☐☐

b) CHART III - Select the examination site you desire and enter Test Center Code: ☐☐☐☐

c) CHART IV - Find your School of Graduation and enter school code: ☐

d) Record the number of times you have taken this exam in Illinois or any other state: ☐☐

PART VIII: Child Support and/or Student Loan 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 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.)

   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 ☐ No ☐

PART IX: 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.

NAME (Last, First, MI):

SS#:

Profession:

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

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

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? *	☐	☐
2)	Are you currently charged with or have you 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 _____ Date _____

* DEFINITIONS

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

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

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

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

An attempt to commit any of these offenses.

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

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

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

(1.7) (Blank).

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

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

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

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

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

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

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

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

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

* DEFINITIONS

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

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

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

CERTIFICATION BY LICENSING AGENCY / BOARD

SUPPORTING DOCUMENT

CT

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. Profession Name ____ Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___	
8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)	8b. LICENSE NUMBER (If applicable)	8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize _____ to furnish to the Illinois Department of
Name of Licensing Agency or Board
Financial and Professional Regulation or its designated testing service, the information requested below.

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

LICENSING AGENCY: The Illinois Department of Financial and Professional Regulation will accept other forms of certification provided all applicable information requested on this form is contained in the certification. Please record N/A in areas which are not applicable.

PART I - CERTIFICATION OF EXAMINATION STATUS

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

_____ Name of Examination _____ Date of Examination

B. The applicant has or will have written the above-named examination _____ number of times.

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE	B. LICENSE NUMBER
C. ISSUANCE DATE OF LICENSE	D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD

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

F. CURRENT LICENSURE STATUS

- ☐ Active
- ☐ Inactive
- ☐ Lapsed
- ☐ Other (Explain) _____

G. IF LICENSED BY EXAMINATION, RECORD SCORES

Type of Examination	Score
Written	_____
Practical	_____
Other (Describe) _____	
Received no Grade Below	_____

Examination Period _____ days _____ hours

NAME (Last, First, MI):

SS#:

Profession:

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination — Date of Examination _____

(Record all available information)

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.

SEAL

Print Name

Title

Signature

Agency/Board Street Address

Date

City, State, ZIP Code

Area Code ( )

Telephone Number

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

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 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

SUPPORTING DOCUMENT

ED

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH
__ __ / __ __ / __ __ __ __
Month Day Year

3. SOCIAL SECURITY NUMBER
__ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Profession Name ___ ___ ___ Profession Code

6. MAIDEN OR GIVEN SURNAME

7. NAME OF INSTITUTION ATTENDED

8. DATE OF GRADUATION / COMPLETION
__ __ / __ __ / __ __ __ __
Month Day Year

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date

Signature of Applicant

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

A. NAME OF INSTITUTION

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE

C. DEPARTMENT OF INSTITUTION

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT

E. MAJOR AREA OF STUDY OF THE APPLICANT

F. APPLICANT WAS (CHECK ONE):
☐ Full-time ☐ Part-time ☐ Co-op

G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
☐ _____ Semester Hours
☐ _____ Quarter Hours
☐ _____ Course Hours

H. DATES OF ATTENDANCE
From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __
Month Day Year Month Day Year

I. Total academic years attended _____ _____ _____
Years Months Days
OR
Total calendar years attended _____ _____ _____
Years Months Days

J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)

K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET
__ __ / __ __ / __ __ __ __
Month Day Year

L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED
__ __ / __ __ / __ __ __ __
Month Day Year

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

☐ Applicant has graduated on __ __ / __ __ / __ __ __ __
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

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

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

NAME (Last, First, MI):

SS#:

Profession:

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

SCHOOL SEAL OR NOTARY SEAL

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

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

Date of Expiration

Signature of Notary Public

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 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

ACADEMIC COURSEWORK AND PRACTICUM

SUPPORTING DOCUMENT

ACW-MFT

APPLICANT: Complete a separate form for each institution in which you have completed graduate coursework. You may copy this form as needed.

This form is not necessary if you are either a Clinical Member of the American Association for Marriage and Family Therapy or have a graduate degree from a program approved by the Illinois Department of Financial and Professional Regulation as an Approved Comprehensive Program of Study in Marriage and Family Therapy. (See Instruction Sheet to determine what proof to submit instead.)

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. ☐ Associate Licensed Marriage and Family Therapist (208) ☐ Licensed Marriage and Family Therapist (166)	
6. MAIDEN OR GIVEN SURNAME		
7. NAME OF COLLEGE/INSTITUTION	8. DEPARTMENT	
9. ADDRESS OF COLLEGE/INSTITUTION	10. PROGRAM (AREA OF SPECIALIZATION AS IT APPEARS ON TRANSCRIPT.)	

A. ACADEMIC COURSEWORK: Indicate which specific courses or equivalent experiences you believe to meet the course areas listed below. Course descriptions and syllabi are required for courses whose titles do not reflect the content area listed below.

AREA	COURSE TITLE	COURSE NO.	YEAR	CREDITS	SEMESTERS OR QUARTERS
Individual Development and Family Studies 1 course: 3 semester hours					
Theoretical Foundations and Clinical Practice[1] 6 courses: 18 semester hours					
Professional Studies and Ethics 1 course: 3 semester hours					
Research 1 course: 3 semester hours					

[1] **The course work in this subsection must balance methods for working individually (one client in a therapy session), and for working conjointly with at least two clients present in therapy sessions who are in significant relationships with each other outside the therapy context, and must include methods for working with groups.**

NAME (Last, First, MI):

SS#:

Profession:

B. PRACTICUM OR INTERNSHIP (300 hours)

This practicum or internship occurred ☐ during my 1st qualifying degree ☐ after completion of 1st qualifying degree

SITE NAME		SUPERVISOR NAME/DEGREE	
SITE ADDRESS		SUPERVISOR'S BUSINESS/INSTITUTION NAME/ADDRESS	
TOTAL HOURS WORK EXPERIENCE	TOTAL FACE-TO-FACE CONTACT HRS	STARTING DATE	ENDING DATE

C. MANDATORY TOPICS:

Indicate which specific courses or equivalent experiences you believe meet the mandatory topic areas listed below. Please note that the same course may be used to cover more than one mandatory topic area.

MANDATORY TOPICS	LIST AT LEAST ONE COURSE WHERE TOPIC WAS COVERED	COURSE NO.	YEAR
Historical Development, Theoretical and Empirical Foundations, and Contemporary Directions			
Overview of the Major Clinical Theories of Marital and Family Therapy			
Assessment and Evaluation of Individuals, Couples and Families			
Treatment and Intervention Methods for Working with Individuals, Couples, Families, and Groups in Therapy			
Assessment and Treatment of Mental, Emotional, Behavioral and Interpersonal Disorders and Psycopathology			
Contemporary Issues			
Crisis Intervention			

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

VERIFICATION OF SELF-EMPLOYMENT/EXPERIENCE

SUPPORTING DOCUMENT

VSE-MFT

APPLICANT: ***Complete the applicant section of this form. Forward the form to an individual who will attest to personal knowledge of your employment/experience. The completed form must be returned to you for inclusion with your Application for Licensure/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.

_____ ___ ___ ___
Profession Name Profession Code

6. MAIDEN OR GIVEN SURNAME

REFERENT: ***Complete the remainder of this form. <u>RETURN THE COMPLETED FORM TO THE APPLICANT IN A SEALED ENVELOPE</u>.***

PART I. - COLLEAGUE/CO-WORKER/CLIENT INFORMATION

A. NAME

B. BUSINESS/INSTITUTION NAME

C. COLLEAGUE/CO-WORKER LICENSE NUMBER (If Applicable

D. YOUR RELATIONSHIP TO APPLICANT

☐ Colleague ☐ Co-worker ☐ Client

PART II. - APPLICANT EMPLOYMENT INFORMATION

A. TIME DURING WHICH YOU KNEW APPLICANT TO BE PRACTICING AT THE ABOVE LOCATION

From __ __ / __ __ / __ __ __ __ To __ __ / __ __ / __ __ __ __
Month Day Year Month Day Year

B. RECORD YOUR ASSOCIATION TO THE APPLICANT'S WORK EXPERIENCE.

I do hereby declare that the information I have recorded hereon is true and correct.

Signature

Referent Street Address

Date

City, State, Zip Code

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

PROFESSIONAL/CLINICAL EXPERIENCE

SUPPORTING DOCUMENT

PCE-MFT

APPLICANT: You are authorized to photocopy this form if additional space is required.

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	8. DATE FORM COMPLETED	

A. NAME OF AGENCY / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	

PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)

☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE

CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)

TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY

B. NAME OF AGENCY / INSTITUTION	JOB TITLE
ADDRESS STREET, CITY , STATE, ZIP CODE	DESCRIPTION OF DUTIES PERFORMED
SUPERVISOR NAME	

PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)

☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE

CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)

TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY

NOTE: This form must be completed by all applicants.

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF AGENCY / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY , STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

D. NAME OF AGENCY / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY , STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

E. NAME OF AGENCY / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY , STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
SUPERVISOR NAME			
PROFESSIONAL WORK EXPERIENCE (3000 HOURS REQUIRED)			
☐ FULL-TIME POSITION ☐ PART-TIME POSITION	EMPLOYMENT STARTING DATE	EMPLOYMENT ENDING DATE	TOTAL HOURS WORK EXPERIENCE
CLINICAL EXPERIENCE (350 HOURS CONJOINT, 350 HOURS WITH INDIVIDUALS; TOTAL OF 1000 HOURS)			
TOTAL HOURS OF CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT**	NUMBER OF THESE HOURS PROVIDING **INDIVIDUAL** THERAPY	NUMBER OF THESE HOURS PROVIDING **CONJOINT** THERAPY	

PLEASE SUM THE TOTALS INCLUDED ON THIS FORM

GRAND TOTAL PROFESSIONAL WORK EXPERIENCE HOURS RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT **REGARDLESS OF THERAPY FORMAT** RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT PROVIDING **INDIVIDUAL** THERAPY RECORDED ON THIS FORM	GRAND TOTAL HOURS OF CLINICAL FACE-TO-FACE CLIENT CONTACT PROVIDING **CONJOINT** THERAPY RECORDED ON THIS FORM
3000 HOURS REQUIRED	1000 HOURS REQUIRED	350 HOURS REQUIRED	350 HOURS REQUIRED

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CLINICAL SUPERVISION WORKSHEET

SUPPORTING DOCUMENT

CSW-MFT

APPLICANT: Complete and return this form to the Department of Professional Regulation.

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.

Licensed Marriage & Family Therapist Profession Name — **1 6 6** Profession Code

6. MAIDEN OR GIVEN SURNAME

CLINICAL SUPERVISION (200 HOURS)

	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
1.		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required fo (pick one). ☐ MFT Supervision OR ☐ MH Supervision
2.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required fo (pick one). ☐ MFT Supervision OR ☐ MH Supervision
3.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required fo (pick one). ☐ MFT Supervision OR ☐ MH Supervision
4.	SUPERVISOR NAME, DEGREE, INSTITUTION ADDRESS, PHONE	SUPERVISION HOURS	PRE OR POST DEGREE	MFT OR MH SUPERVISION
		Total Supervision Hours Starting Date Ending Date	This supervision occurred (pick one): ☐ During my first qualifying degree OR ☐ After completion of first qualifying degree	Please count this supervision as part of the hours required fo (pick one). ☐ MFT Supervision OR ☐ MH Supervision

TOTALS OF THE CLINICAL SUPERVISION RECORDED ON THIS PAGE:

TOTAL SUPERVISION HOURS THAT ARE RECORDED ON THIS PAGE AND WERE COMLETED **DURING** MY FIRST QUALIFYING DEGREE.	TOTAL **MARRIAGE AND FAMILY THERAPY** SUPERVISION HOURS RECORDED ON THIS PAGE
TOTAL SUPERVISION HOURS THAT ARE RECORDED ON THIS PAGE AND WERE COMLETED **AFTER** MY FIRST QUALIFYING DEGREE.	TOTAL **MENTAL HEALTH** SUPERVISION HOURS RECORDED ON THIS PAGE

NOTE: This form is not necessary if one is a Clinical Member of the American Association for Marriage and Family Therapy. An applicant may accumulate up to 100 hours of the required 200 hours of clinical supervision during graduate training for the first qualifying degree. Regardless of whether the supervision took place prior to or after graduation, the applicant must have at least 100 hours of supervision with a supervisor qualified to provide marriage and family therapy supervision as defined by this license. To determine if your supervisor is qualified to provide marriage and family therapy supervision, refer to the act and rules then complete form SR-MFT for each supervisory experience.

IMPORTANT! PLEASE HAVE EACH CLINICAL SUPERVISOR LISTED ABOVE COMPLETE AN SR-MFT FORM.

THIS FORM MAY BE DUPLICATED IF NEEDED.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 55/1 et. seq.(Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

SUPERVISOR'S REPORT

SUPPORTING DOCUMENT

SR-MFT

APPLICANT: Complete section 1-10 and forward this form to supervisor for completion.

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. **Licensed Marriage & Family Therapist** Profession Name **1 6 6** Profession Code	
6. MAIDEN OR GIVEN SURNAME		
7. SUPERVISOR NAME	8. SUPERVISOR'S BUSINESS PHONE	
9. SUPERVISOR'S INSTITUTION OR AGENCY NAME	10. SUPERVISOR'S ADDRESS, STREET, CITY, STATE, ZIP CODE	

SUPERVISOR: Complete the remainder of this form. Return the completed form directly to the Department of Financial and Professional Regulation, ATTN: Division of Professional Regualtion, 320 West Washington - HSS1, Springfield, IL 62786.

PART I - SUPERVISOR INFORMATION

A. SUPERVISOR NAME/DEGREE	B. SUPERVISOR'S LICENSE NO.	C. STATE & DATE OF ISSUANCE
D. SUPERVISOR'S AGENCY OR INSTITUTION AND ADDRESS	E. SUPERVISOR'S WORK PHONE	
	F. STARTING DATE OF SUPERVISION	G. ENDING DATE OF SUPERVISION

H. Please check the (one) box below that accurately reflects your training, experience, certification, and/or licensing at the time supervision took place and provide supporting documentation as indicated. See Instruction Sheet for definition of terms.

The supervision you provided may count as marriage and family therapy (MFT) supervision if **one** of the following is true (Check **only** one box):

- ☐ I am certified as an Approved Supervisor or Supervisor-in Training by the American Association for Marriage and Family Therapy. (Please enclose a photocopy of proof of certification.)
- ☐ I hold an active license as a licensed marriage and family therapist with 5 years clinical experience after my first qualifying degree.
- ☐ I have held an active clinical membership certification with the American Association for Marriage and Family Therapy for at least 5 years. (Please enclose a photocopy of proof of clinical membership.)
- ☐ I have
  - a) an active license as a psychiatrist, licensed clinical psychologist, licensed clinical social worker, or licensed clinical professional counselor and
  - b) 5 years clinical experience providing marriage and family therapy and
  - c) provided at least 1000 hours of conjoint therapy and
  - d) either 2 years experience providing clinical supervision of marriage and family therapy (including the supervision of conjoint therapy) or have completed a 1-semester hour graduate course in marriage and family therapy supervision (at least 15 contact hours) or the equivalent prior to or during the supervision provided the applicant. (Please enclose a written statement attesting to how you have met requirements b through d.)

The supervision you provided may count as mental health (MH) supervision if the following is true:

- ☐ I am a licensed psychiatrist, licensed clinical psychologist, licensed clinical social worker, or a licensed clinical professional counselor with 5 years experience in my discipline.

NOTE: An applicant must have a supervisor qualified to provide marriage and family therapy supervision as defined above for at least 100 of the 200 hours of supervision in order to meet the supervision requirements of this license.

PART II - SUPERVISION INFORMATION

I. This supervision experience occurred:
(Please select one.) ☐ during the applicant's 1st qualifying degree ☐ after completion of the applicant's 1st qualifying degree.

J. INDICATE YOUR OVERALL EVALUATION OF THE APPLICANT'S PERFORMANCE AS A MARRIAGE AND FAMILY THERAPIST.

EXCELLENT		SATISFACTORY		POOR
5	4	3	2	1

K. COMMENTS - INCLUDE ANY COMMENTS REGARDING THE APPLICANT'S JOB PERFORMANCE.

L. COMPLETE THE FOLLOWING:	M. FORMATS OF SUPERVISION (CHECK ALL THAT APPLY):
FREQUENCY OF SUPERVISION APPOINTMENTS	☐ LIVE SUPERVISION
DURATION OF EACH SUPERVISION APPOINTMENT	☐ CO-THERAPY
TOTAL HOURS OF CLINICAL SUPERVISION	☐ VIDEO TAPE REVIEW ☐ AUDIO TAPE REVIEW ☐ CASE NOTES AND CONSULTATION

N. I have read the guidelines regarding supervision established for the marriage and family therapy license and certify that the supervision conducted with this application complies with these standards. ☐ Yes ☐ No

Under the penalties of perjury, I certify that the information provided regarding the supervision provided to the applicant and my training, experience, certification and/or licensing is true and correct.

Signature: _____

Title: _____ Date: _____

NAME (Last, First, MI):

SS#:

Profession:

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.

VERIFICATION OF EMPLOYMENT / EXPERIENCE

SUPPORTING DOCUMENT

VE

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 __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year	9. SUPERVISOR NAME	

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

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 __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year

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