INSTRUCTION SHEET

CHIROPRACTIC PHYSICIAN

Endorsement
Acceptance of Examination
Restoration
Visiting Professor

BEFORE COMPLETING THE APPLICATION PACKAGE, read the instructions as listed below 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 by the Department. FEES ARE NOT REFUNDABLE.**

PLEASE NOTE: **Do not use this application to apply to take the National Board of Chiropractic Examiners Examination**. In order to apply for that examination, graduates should contact the National Board of Chiropractic Examiners, 901 54th Avenue, Greeley, Colorado 80634, or on-line at **www.nbce.org**.

General Instructions

1. Complete the four-page Application for Licensure/Examination. Next locate the specific instructions for the licensure method under which you are applying and follow those instructions only.
2. All documents submitted in a foreign language must be accompanied by an 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.
3. If assistance is needed, direct your request to the following telephone number:

   1-800-560-6420

NOTICE

All individuals applying for initial licensure as a physician or chiropractic physician in Illinois ***must*** submit to a criminal background check and provide evidence of fingerprint processing from the Illinois State Police, or its designated agent. See attached **"Important Notice--Criminal Background Check Requirement"** for more information concerning this requirement.

4-Page Application

1. Part I-A, Application Category Information—Complete as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Chiropractor	038	Endorsement	$500.00
Chiropractor	038	Acceptance of Examination	$500.00
Chiropractor	038	Restoration	*
Visiting Professor	114	Nonexamination	$300.00

*See Supporting Document **RS** for fee amount.

4-Page Application (cont'd)

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 in numbers 1 through 10.

4. Part III, Education Information.

   a. Enter all applicable information requested.

   b. In Number 6, indicate both Pre-Chiropractic and Chiropractic Education.

   c. MINIMUM EDUCATION REQUIREMENTS - An applicant who is a matriculant in a chiropractic college after September 1, 1969, shall be required to complete a two-year course of instruction in a liberal arts college or its equivalent, followed by a course of instruction in a chiropractic college in the treatment of human ailments, such course, as a prerequisite to graduation therefrom, having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

      An applicant who is a graduate of a United States chiropractic college after August 19, 1981, must graduate from a college fully accredited by the Commission on Accreditation of the Council on Chiropractic Education or its successor at the time of graduation. Such graduates shall be considered to have met the minimum requirements which shall be in addition to those requirements set forth in the Rules and Regulations promulgated by the Department.

      The standards of education for an applicant who is a graduate of a chiropractic college in another country must be equivalent to the standards of education as set forth for chiropractic colleges located in the United States.

5. Part IV, Record of Licensure Information--Indicate any license, or any related license, or authorization held as a chiropractor in the U. S. or a foreign country.

6. Part V, Record of Examination--List all NBCE and/or state constructed examinations and attempts taken to *qualify* for chiropractic licensure. **Each** examination attempt and date taken **must** be shown.

7. Part VI, Personal History Information--See Page 3.

8. Part VII, Examination Coding Information--Not Applicable.

9. Part VIII, Child Support and Student Loan Information--This part must be completed by all applicants.

10. Certifying Statement--Read the certifying statement and then sign and date your application.

PERSONAL HISTORY INFORMATION INSTRUCTIONS

You must answer all 6 questions. If any of your responses to numbers 1 through 6 are "yes," submit a detailed statement explaining your affirmative response and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

Questions 1 and 2

A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s); if probation given, verification that probation was completed satisfactorily; a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

Submit a statement for each conviction indicating date and place of conviction, nature of the offense, and if applicable, the date of discharge from any penalty imposed.

Question 3

If you have been issued a Certificate of Relief from Disabilities by the Prisoner Review Board, you must include a copy of the certificate.

Question 4

A report from any and all physicians, counselors, or therapists from whom you have received treatment for any chronic disease or condition (i.e., chemical/alcohol dependency, depression, etc.). The report must include dates of treatment, method of treatment, diagnosis, and prognosis. Attach a detailed statement advising whether you are currently under treatment.
Submit a copy of each of your treating physician's curriculum vitae and verification of board certification if board certified in a specialty.

If you have been treated as an inpatient/outpatient at any time for any disease or condition, then it will be necessary for you to have the institution(s) submit, directly to this Department, copies of any and all admitting histories, physicals and discharge summaries for each inpatient/outpatient stay or treatment.

Question 5

A detailed explanation is required if you have 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. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 6

If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to this Department, any and all information relative to your discharge.

Endorsement / Acceptance of Examination

To apply for licensure as a Chiropractic Physician submit the following documentation with the 4-page application:

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

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

3. Submit official transcript of a two-year course of instruction prerequisite to professional training in a college, university or other institution issued by the school with school seal affixed. These transcripts are not required if you graduated from chiropractic school subsequent to August 19, 1981.

4. Submit official transcript issued by the chiropractic school or university with school seal affixed and certification of graduation. If transcript does not include date of graduation and degree conferred, submit copy of diploma.

5. Supporting Document **CT** must be completed by the jurisdiction of original and current licensure. You are authorized to photocopy this form if necessary.

6. Supporting Document **VE-PC (Verification of Employment/Experience--Professional Capacity)** must be completed by all applicants. Record your work history chronologically for the five (5) years preceding the date of application beginning with present employment.

   If you have not been actively engaged in the practice of chiropractic or been a student engaged in a formal program of chiropractic education during the 2 years immediately preceding the filing of your application, you must submit evidence to establish your present capacity to practice medicine with reasonable judgment, skill and safety. Refer to page 8 of this application packet for additional information.

7. Instruct the National Board of Chiropractic Examiners to forward directly to this Department, verification of successful completion of Parts I, II, III and IV of their examination.

   In addition, request the National Board to forward official transcripts of your complete pass/fail examination history.

   a. The Medical Licensing Board can require an applicant to successfully complete the Special Purposes Exam for Chiropractic (SPEC) or Part III of the National Board of Chiropractic Examiners Examination when it is determined that the requirements for licensure of the applicant were not substantially equivalent to the requirements for licensure in this State at the date of the applicant's license.

   b. The Board may recommend waiving the requirements of Part III of the examination or the SPEC requirement when an applicant submits evidence of outstanding and proven ability in chiropractic. The Board shall consider the quality of the chiropractic education and practical experience, including, but not limited to, whether he/she is Board Certified in a specialty, has achieved special honors or awards, has had articles

Endorsement (cont'd)

published in recognized and reputable journals, or has written or participated in the writing of textbooks in chiropractic.

8. Fee payment is indicated on page 1 of these instructions. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.

9. Forward 4-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P. O. Box 7007, Springfield, Illinois 62791.

Restoration

To restore your Chiropractic Physician license you must submit with the 4-page application the following documentation:

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

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

3. Submit completed Supporting Document **RS**. 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.

4. **CME Requirement--**Proof of meeting the continuing medical education (CME) requirements for one renewal period. Submit proof of completion of 150 hours of CME completed in the three years immediately preceding your restoration application. A minimum of 60 hours must be Category I CME verified by copies of certificates of completion and maximum of 90 hours may be self-verified and obtained in informal Category II activities. (See Addendum entitled "Restoration Continuing Education Facts for Chiropractic Physicians," on page 9.)

5. Submit one of the following: (If Supporting Document **VE** is not included in the application packet, you must obtain one by contacting the Department of Financial and Professional Regulation at 217-782-0458.)

   a) Supporting Document **VE** (Verification of Employment/Experience) must be completed to provide documentation of active practice in another jurisdiction. In addition, a **CT** form (Certification of Licensure) must be submitted from that jurisdiction (board or licensing authority) indicating you were authorized to practice during the term of said active practice. If private practice, in lieu of **VE** Form, submit sworn statement attesting to your active practice in said jurisdiction;

or

> **~IMPORTANT NOTICE~**
>
> These Restoration Instructions apply only to those chiropractic physicians 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.**

b) Supporting Document **ED** must be completed which verifies 960 classroom hours (1 academic year) by an official from an accredited chiropractic program within three years from the date of application for restoration;

or

c) Verification of successful completion of the **Special Purposes Examination for Chiropractic (SPEC)** within 3 years from the date of application. To be successful you must receive a score of 75 or higher;

or

d) Submit copy of **DD214** if restoring after active military service.

6. 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.

7. Forward 4-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation P. O. Box 7007, Springfield, Illinois 62791.

Visiting Chiropractic Professor Permit

In order to obtain a permit to practice as a Visiting Chiropractic Professor, you must submit the following documentation with the 4-page Application for Licensure and/or Examination.

1. Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document PH **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
3. Supporting Document **CT** must be completed by the jurisdiction of original licensure and submitted with the application.
4. Supporting Document **VE-PRO** must be completed by the dean of a program of medicine located in another jurisdiction certifying that you were qualified and held professor status at said institution.
5. Submit a current Curriculum Vitae.
6. Supporting Document **DC-VPR** must be completed.
7. Fee payment is indicated on page 1 of these instructions. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation.
8. Forward 4-page application, supporting documentation, and fee payment to: Illinois Department of Financial and Professional Regulation, Attn: Division of Professional Regulation, P.O. Box 7007, Springfield, Illinois 62791.

NOTE: A Visiting Chiropractic Professor Permit shall be valid for two (2) years from the date of issuance or until the faculty appointment is terminated, whichever occurs first. The permit may be renewed.

PROFESSIONAL CAPACITY

In determining Professional Capacity, the Department shall consider, but not be limited to, the following activities completed in the two years immediately preceding your application for licensure:

Medical Research

Medical research shall be human clinical research that is consistent with the Federal Food and Drug Administration and the Consumer Product Safety Commission.

Special Training or Education

Specialized training or education shall be clinical training or clinical education such as the following: a) clinical training that takes place in a residency training program recognized by the Department, b) clinical medical practice in the National Health Service, c) 150 hours of Category 1 continuing medical education recognized by the American Council on Continuing Medical Education, the American Osteopathic Association, American Chiropractic Association, or continuing medical education in accordance with the Rules for the administration of the Illinois Medical Practice Act, d) postgraduate education in the basic or related medical sciences.

Published

Your original work in clinical medicine published as first author in medical or scientific journals that are listed by the Cumulative Index Medicas (CIM).

Public Clinical Research

Clinical research or professional clinical medical practice in public health organizations (e.g. World Health Organization, Malaria Prevention programs, United Nations International Children's Emergency Fund programs, etc.).

Federal Clinical Research

Clinical research or clinical medical practice at a veterans, military, or other medical institution operated by the federal government.

Other

Other professional or clinical medical activities such as a) presentation of papers or participation on panels as a faculty member at a program approved or recognized by the American Medical Association or an affiliate, the American Osteopathic Association or an affiliate, the American Chiropractic Association or an affiliate, or a specialty society or equivalent that is recognized by the medical community; or b) experience obtained as a Visiting Professor in accordance with Section 18(a) of the Illinois Medical Practice Act of 1987.

ADDENDUM

RESTORATION CONTINUING EDUCATION FACT SHEET FOR CHIROPRACTIC PHYSICIANS

APPROVED CONTINUING MEDICAL EDUCATION HOURS

CME hours shall be earned by, but not limited to, verified attendance at, or participation in, a program/course as follows:

☐ A minimum of, but not limited to, 60 hours of required CME shall be obtained in Formal CME programs; i.e., Category 1:

A) Formal programs conducted or endorsed by hospitals, specialty societies, facilities or other organizations approved to offer CME credit;

B) formal programs conducted by medical, chiropractic or osteopathic education programs, including the Council on Continuing Medical Education of the American Osteopathic Association, the Commission on Accreditation of the Council of Chiropractic Education Schools, either to prepare individuals for licensure pursuant to the provisions of the Act or for postgraduate training;

C) CME programs required for certification or recertification by specialty boards and professional associations;

D) activities which are given by sponsors approved in accordance with this Section:

   i) CME utilizing enduring materials designated as a formal program (Category 1) such as CD-ROMS, printed education materials, audiotapes, video cassettes, films, slides and computer assisted instruction;

   ii) journal club activities which have been designated as a formal program (Category 1);

   iii) self-assessment activities; and,

   iv) journal-based CME.

☐ A maximum of 90 hours of required CME hours may be obtained in informal CME programs (i.e., Category 2):

A) Consultation with peers and experts concerning patients;

B) use of electronic databases in patient care;

C) small group discussions;

D) teaching health professionals;

E) medical writing;

F) teleconferences;

G) preceptorships;

H) participating in formal peer review and quality assurance activities;

I) preparation of educational exhibits;

J) journal-readings;

K) enduring materials not designated as a formal activity; and,

L) journal club activities not designated as a formal activity.

APPROVED CME SPONSORS

Approved Sponsor shall mean an entity/activities accredited by one of the following:

A) Accreditation Council on Continuing Medical Education (ACCME) and organizations accredited by ACCME as sponsors of CME;

B) Illinois State Medical Society, or its affiliates;

C) Council on Continuing Medical Education of the American Osteopathic Association and the Illinois Osteopathic Medical Society, or its affiliates;

D) Illinois Chiropractic Society, or its affiliates;

E) Illinois Prairie State Chiropractic Association, or its affiliates;

F) International Chiropractic Association, or its affiliates;

G) American Chiropractic Association, or its affiliates; or

H) any other accredited school, college or university, state agency, any other person, firm, or association which has been approved and authorized by the Department.

IMPORTANT NOTICE

CRIMINAL BACKGROUND CHECK INFORMATION

Individuals applying for licensure for professions that require fingerprints must submit to a criminal background check and provide evidence of fingerprint processing from a fingerprint vendor licensed by the Department. **Fingerprints must be taken within 60 days from the date that the application is submitted to the Department or the Department's testing vendor.**

- Applicants may contact a licensed fingerprint vendor to schedule an appointment for fingerprinting by going to https://www.idfpr.com/FPVendor.asp. The Illinois State Police will transmit electronic results of fingerprint processing to the Department. A receipt issued by a licensed fingerprint vendor agency must be submitted with the application fee. The receipt shall be issued by the fingerprint vendor at the time the fingerprints are obtained.

- Out-of-State applicants who are unable to schedule an appointment for fingerprinting through a licensed fingerprint vendor need to complete the following steps:

  - Obtain one (1) Illinois State Police (ISP) Fee Applicant Card for processing. Applicants may contact the Department at 1-800-560-6420 or send an email request on your profession page of the Department website at www.idfpr.com. The ISP will transmit electronic results of the fingerprint processing to the Department.

  - Complete Section 1 of the **Identity Verification Certifying Statement** form.

  - The Fee Applicant Card shall be taken to a police department in **another state** to obtain classifiable prints.

  - Section 2 of the **Identity Verification Certifying Statement** shall be completed and signed by the police department.

  - Go to www.idfpr.com to select a licensed fingerprint vendor that has "Card Scan" capability. Contact the vendor to determine the fee for a "Card Scan".

  - Mail the original **Identity Verification Certifying Statement** (with Sections 1 and 2 completed), Fee Applicant card and fingerprint fee to the licensed fingerprint vendor selected from the Division of Professional Regulation website.

  - Mail the completed application, licensing fee and a copy of the **Identity Verification Certifying Statement** (with Sections 1 and 2 completed) to the Division of Professional Regulation.

PRIVACY STATEMENT

I, the undersigned, hereby authorize the release of any criminal history record information that may exist regarding me from any agency, organization, institution, or entity having such information on file. I am aware and understand that my fingerprints may be retained and will be used to check the criminal history record information files of the Illinois State Police and/or the Federal Bureau of Investigation. I also understand that if my photo was taken, my photo may be shared only for employment or licensing purposes. I further understand that I have the right to challenge any information disseminated from these criminal justice agencies regarding me that may be inaccurate or incomplete pursuant to Title 28 Code of Federal Regulation 16.34 and Chapter 20 ILCS 2630/7 of the Criminal Identification Act.

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."**

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Chiropractic Physicians

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

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

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

SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
Supporting Documents CCA and PH **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 jurisdictions of ***original*** and ***current*** licensure	
VE-PC Form	
Official transcript verifying 2-year course of instruction, if applicable	
Proof of chiropractic education (official transcript of grades issued by the chiropractic college or university with school seal affixed) including date of graduation and degree conferred	
Chiropractic School Diploma (copy), if applicable	
Examination scores directly from the **NBCE**	
Criminal Background Check	
RS Form (restoration only)	
CME requirement (150 hours)--copies of certificates verifying a minimum of 60 hours or Category I CME and documentation of completion of Category II CME (restoration only) **VE** Form; or **ED** Form; or **DD214** or **SPEC** examination (restoration only)	

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 ___ ___ / ___ ___ / ___ ___ ___ ___ (Month Day Year)

10. AGE ____ ☐ 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.

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		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	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

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)*

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

1. In accordance with 5 Illinois Compiled Statutes 100/10-65(c), applications for renewal of a license or a new license shall include the applicant's Social Security number, and the licensee shall certify, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order. **Failure to certify shall result in disciplinary action, and making a false statement may subject the licensee to contempt of court.**

   Are you more than 30 days delinquent in complying with a child support order? Yes ☐ No ☐
   (NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

   Are you delinquent in the filing of state taxes? Yes ☐ No ☐

PART VIII: Certifying Statement

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

____________________________ Signature of Applicant

____________________________ Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than $50.

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	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.**

- ☐ 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
- ☐ Medication Aide
- ☐ 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:

	Question	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 ____________ 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.

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ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION PERSONAL HISTORY INFORMATION

SUPPORTING DOCUMENT

PH

NAME LAST FIRST MIDDLE	SOCIAL SECURITY NUMBER __ __ __–__ __–__ __ __ __

In order for your application to be evaluated, you must respond to each of the following questions:	YES	NO
1. Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation.		
2. Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? *If yes, attach a separate sheet with complete and accurate explanation.*		
3. Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. *If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action.*		
4. Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation.		
5. Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		
6. Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? *If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.*		
7. Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. *If yes, attach a separate sheet with a complete and accurate explanation and request all official disciplinary documents including initial complaint, stipulations, orders or reprimands be sent directly to the Department.*		

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

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-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

	Profession Code
☐ Permanent Physician License	036
☐ Temporary Physician Training License	125
☐ Chiropractic Physician License	038

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

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

5. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment. Also list any breaks of six (6) months or longer in medical practice since graduation from medical school.

A. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

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

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

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

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

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

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF PRACTICE / WORK LOCATION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

D. NAME OF PRACTICE / WORK LOCATION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

E. NAME OF PRACTICE / WORK LOCATION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

F. NAME OF PRACTICE / WORK LOCATION		JOB TITLE
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED
DATE OF EMPLOYMENT/ATTENDANCE From __ __ / __ __ / __ __ __ __ Month Day Year To __ __ / __ __ / __ __ __ __ Month Day Year	HOURS WORKED PER WEEK TYPE OF EMPLOYMENT ☐ Full-time ☐ Part-time	
TOTAL TIME WORKED (Year/Month)		

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

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

____
Title

____
Signature

____
Agency/Board Street Address

____
Date

Area Code (   )
____
Telephone Number

____
City, State, ZIP Code

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 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.

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.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 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 PROFESSOR STATUS

SUPPORTING DOCUMENT

VE-PRO

APPLICANT: ***Complete the applicant section of this form. Forward the form to the Dean of the School at which you held professor status. Return the completed form with the 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. PROFESSION NAME AND CODE. **Visiting Professor Physician** ___ ___ ___ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME		

DEAN OF MEDICAL SCHOOL: ***Complete the remainder of this form. Return the completed form to the applicant.***

A. NAME OF MEDICAL PROGRAM (Medical, Osteopathic, or Chiropractic College)

B. LOCATION OF MEDICAL PROGRAM (Street, City, State, ZIP Code)

I hereby certify that ______________________________

held professor status at this institution from ______________ to ______________.

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

S E A L

____
Signature of Dean

____
Date

____
Print Name of Dean

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CERTIFICATION OF CONTRACTUAL AGREEMENT FOR VISITING PROFESSOR

SUPPORTING DOCUMENT

DC-VPR

NOTE: *An applicant shall not commence a faculty appointment before the program director receives written notification of application approval from the Department of Financial and Professional Regulation.*

The initial Visiting Professor Permit shall be valid for 2 years or for the term of the faculty appointment if less than 2 years. The applicant may be required to appear before the Board for an interview prior to the issuance of the original permit.

APPLICANT: ***Complete the applicant section of this form. Forward the form to the Dean of the School at which the contract has been established. Return the completed form with the Application for Licensure/ Examination at least 60 days prior to the beginning date of the faculty appointment.***

1. NAME LAST FIRST MIDDLE

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

3. SOCIAL SECURITY NUMBER
___ ___ ___ - ___ ___ - ___ ___ ___ ___

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. PROFESSION NAME AND CODE.

Visiting Professor Physician ___ ___ ___
Profession Name Profession Code

6. MAIDEN OR GIVEN SURNAME

7. TYPE OF PERMIT
[ ]Original
[ ]Renewal

8. IF RENEWAL, RECORD ORIGINAL PERMIT NUMBER

DEAN OF SCHOOL: ***Complete the remainder of this form, then return the form to the applicant.***

A. NAME OF SCHOOL (Medical, Osteopathic, or Chiropractic School)

B. DEPARTMENT NAME

C. LOCATION OF SCHOOL (Street, City, State, Zip Code)

D. TELEPHONE NUMBER (Include Area Code)

E. DATES OF APPOINTMENT
From __ __/__ __/__ __ __ __ To __ __/__ __/__ __ __ __
Month Day Year Month Day Year

F. FAX NUMBER (Include Area Code)

G. DESCRIBE NATURE OF EDUCATIONAL SERVICE TO BE PROVIDED BY THE APPLICANT AND QUALIFICATION OF APPLICANT

COMPLETE REVERSE SIDE

H. RECORD THE NEED FOR THE SERVICE TO BE PROVIDED BY THE APPLICANT

I. NAME AND ADDRESS OF THE PATIENT CARE CLINICS OR FACILITIES AFFILIATED WITH THE MEDICAL PROGRAM AT WHICH THE APPLICANT WILL BE PROVIDING INSTRUCTION AND/OR PROVIDING CLINICAL CARE AND A JUSTIFICATION FOR ANY CLINICAL ACTIVITIES THAT WILL BE PROVIDED AT THE FACILITIES.

NAME OF CLINIC OR FACILITY	ADDRESS	JUSTIFICATION

I do hereby declare that the above-named applicant has entered into a contractual agreement as a visiting professor with the above-stated contract terms.

S E A L

Signature of Dean

Date

Print or Type Name of Dean

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.	**CERTIFYING STATEMENT OF FINGERPRINT SUBMISSION**	SUPPORTING DOCUMENT **FP-MED**

APPLICANT: ***This form must be completed by out-of-state residents unable to utilize the livescan process for fingerprinting in the State of Illinois. Attach this certifying statement with the four-page Application for Licensure and/or Examination as proof of having submitted the required fingerprint cards to the proper authorities.***

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. ☐**Physician** **0 3 6** ☐**Chiropractic Physician** **0 3 8**	
6. MAIDEN OR GIVEN SURNAME		

CERTIFYING STATEMENT

Under penalties of perjury, I declare that I, ___________________________________, have submitted the required fingerprints pursuant to Section 60-9.7 of the Medical Practice Act of 1988 (225 ILCS 60) and the Rules for the Administration of the Act (68 Ill. Adm. Code 1285) to the designated agent of the Illinois State Police for processing.

Date: ____ Signature: ___________________________