

# INSTRUCTION SHEET

## CHIROPRACTIC PHYSICIAN

Endorsement

Acceptance of Examination

Restoration

● Visiting Professor

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

BEFORE COMPLETING THE APPLICATION PACKAGE, read 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 which is given twice a year in March and September. 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](http://www.nbce.org).

### General Instructions

*No Reference Sheet is included with this packet. When supporting documents request you refer to the Reference Sheet, enter the information recorded in Part I-A of the four-page Application for Licensure/ Examination onto the supporting document.*

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:

1-800-560-6450

### 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               | \$700.00 |
| Chiropractor       | 038                | Acceptance of Examination | \$700.00 |
| Chiropractor       | 038                | Restoration               | *        |
| Visiting Professor | 114                | Nonexamination            | \$300.00 |

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

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**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.

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## PERSONAL HISTORY INFORMATION INSTRUCTIONS

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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.

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## Endorsement

To apply for licensure as a Chiropractic Physician on the basis of endorsement, 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. You must direct the licensing agency/board to return completed form CT directly to you.
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 medicine or in a formal program of education during the 2 years immediately preceding the filing of your application, refer to page 8 of this application packet for additional requirements.

If you have not been actively engaged in the practice of medicine or been a medical, osteopathic or chiropractic student or been engaged in a formal program of medical education during the 2 years immediately preceding the filing of your application, submit evidence to establish your present capacity to practice medicine with reasonable judgment, skill and safety.

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

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**Endorsement  
(cont'd)**

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 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.

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***In order for your application to be processed,  
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED  
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**Acceptance of  
Examination**

To apply for licensure as a Chiropractor Physician on the basis of Acceptance of Examination, the following documents must be submitted 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. You must direct the licensing agency/board to return completed form CT directly to you.
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 medicine or in a formal program of education during the 2 years immediately preceding the filing of your application, refer to page 8 of this application packet for additional requirements.

If you have not been actively engaged in the practice of medicine or been a medical, osteopathic or chiropractic student or been engaged in a formal program of medical education during the 2 years immediately preceding the filing of your application, submit evidence to establish your present capacity to practice medicine with reasonable judgment, skill and safety.

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**Acceptance of Examination (cont'd)**

7. Request the National Board of Chiropractic Examiners to forward directly to the Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation proof of your having successfully completed Parts I, II, and III of the National Board of Chiropractic Examiners Examination.

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

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.
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***In order for your application to be processed,  
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with the application and required fee unless otherwise directed in the instructions.***

**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;

**~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.**

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**Restoration  
(cont'd)**

*or*

- 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.

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***In order for your application to be processed,  
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**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.**

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## PROFESSIONAL CAPACITY

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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 Medicus (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

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#### 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.

## LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

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

# IMPORTANT NOTICE

## Elder and Child Abuse Reporting

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

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"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 <b>must</b> be completed and submitted with each application. Your application will not be processed without completion of this form.   |           |
| <b>CT</b> (Certification of Licensure) Form from jurisdictions of <b>original</b> and <b>current</b> licensure  |           |
| <b>VE-PC</b> Form   |           |
| <b>Official transcript</b> verifying 2-year course of instruction, if applicable  |           |
| <b>Proof of chiropractic education</b> (official transcript of grades issued by the chiropractic college or university with school seal affixed) including date of graduation and degree conferred  |           |
| <b>Chiropractic School Diploma</b> (copy), if applicable  |           |
| Examination scores directly from the <b>NBCE</b>  |           |
| <b>RS</b> Form (restoration only)   |           |
| <b>CME requirement</b> (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) <b>VE</b> Form; or <b>ED</b> Form; or <b>DD214</b> or <b>SPEC</b> examination (restoration only) |           |

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

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Visiting Chiropractic Professor

*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  |           |
| <b>CT</b> (Certification of Licensure) Form from jurisdiction of <i>original</i> licensure |           |
| <b>Curriculum Vitae (CV)</b>   |           |
| <b>DC-VPR</b> Form   |           |
| <b>VE-PRO</b> Form   |           |

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

**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<br>_____<br>_____ / _____ / _____<br><small>Month      Day                  Year</small> | 2. DATE OF BIRTH<br>_____ / _____ / _____<br><small>Month      Day                  Year</small>   | 3. SOCIAL SECURITY NUMBER<br>_____ - _____ - _____    |
| 4. ADDRESS    STREET, CITY, STATE, ZIP CODE<br>_____<br>_____   | 5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.<br>_____<br><div style="display: flex; justify-content: space-between;"> <span>Profession Name</span> <span>Profession Code</span> </div> |   |
| 6. MAIDEN OR GIVEN SURNAME<br>_____   | 7. APPLICANT TELEPHONE NUMBER (Daytime)<br>Area Code ( _____ ) _____ - _____   |   |
| 8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)<br>_____            | 8b. LICENSE NUMBER (If applicable)<br>_____  | 8c. ISSUANCE DATE OF LICENSE (If applicable)<br>_____ |

I hereby authorize \_\_\_\_\_ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.

Name of Licensing Agency or Board

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<br>_____  | B. LICENSE NUMBER<br>_____             |
| C. ISSUANCE DATE OF LICENSE<br>_____   | D. EXPIRATION DATE OF LICENSE<br>_____ |
| E. LICENSURE METHOD<br><input type="checkbox"/> Examination (Administered in Your State)<br><input type="checkbox"/> National (Name) _____<br><input type="checkbox"/> State Constructed _____<br><input type="checkbox"/> Other (Name) _____<br><input type="checkbox"/> Endorsement of License (State) _____<br>Acceptance of Examination Results _____<br>(Administered in Another State) _____ |  |
| <input type="checkbox"/> Reciprocity with (State) _____<br><input type="checkbox"/> Waiver/Grandfather _____<br><input type="checkbox"/> Credentials _____<br><input type="checkbox"/> Other (Describe) _____  |  |

|  |  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
|--|--|---------------------|-------|---------|-------|-----------|-------|------------------------|-------|-------------------------|-------|---|--|
| F. CURRENT LICENSURE STATUS<br><input type="checkbox"/> Active<br><input type="checkbox"/> Inactive<br><input type="checkbox"/> Lapsed<br><input type="checkbox"/> Other (Explain) _____<br>_____<br>_____ | G. IF LICENSED BY EXAMINATION, RECORD SCORES<br><table style="width: 100%;"> <tr> <td>Type of Examination</td> <td style="text-align: right;">Score</td> </tr> <tr> <td>Written</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Practical</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Received no Grade Below</td> <td style="text-align: right;">_____</td> </tr> <tr> <td>Examination Period _____ days _____ hours</td> <td></td> </tr> </table> | Type of Examination | Score | Written | _____ | Practical | _____ | Other (Describe) _____ | _____ | Received no Grade Below | _____ | Examination Period _____ days _____ hours |  |
| Type of Examination  | Score  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
| Written  | _____  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
| Practical  | _____  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
| Other (Describe) _____   | _____  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
| Received no Grade Below  | _____  |                     |       |         |       |           |       |                        |       |                         |       |   |  |
| Examination Period _____ days _____ hours  |  |                     |       |         |       |           |       |                        |       |                         |       |   |  |

# 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<br>____ | 3. LICENSURE METHOD | 4. FEE<br>\$ |
|--------------------|----------------------------|---------------------|--------------|

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

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

**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<br>LAST FIRST MIDDLE  | 2. TITLE (e.g., M.D., D.D.S., etc.)                  | 3. UNITED STATES SOCIAL SECURITY NO.<br>_____                                    |
| 4. PERMANENT MAILING ADDRESS<br>STREET CITY STATE/COUNTRY   |  | ZIP CODE COUNTY<br>_____   |
| 5. BUSINESS ADDRESS<br>STREET CITY STATE/COUNTRY  |  | ZIP CODE COUNTY<br>_____   |
| 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<br>CITY STATE/COUNTRY   | 9. DATE OF BIRTH<br>____/____/____<br>Month Day Year | 10. AGE<br>____ <input type="checkbox"/> Female<br><input type="checkbox"/> Male |
| 11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED<br>Work: (____) _____ - _____<br>(Area Code)<br>Home: (____) _____ - _____<br>(Area Code)<br>Fax: (____) _____ - _____<br>(Area Code) |  | 12. PREFERRED e-MAIL ADDRESS(ES) [If available]                                  |

**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<br>____ / ____<br>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<br>(Undergraduate and Graduate) | LOCATION<br>(City and State or Country) | DATES OF ATTENDANCE |            | TYPE OF DEGREE EARNED |
|---|---|---------------------|------------|-----------------------|
|   |   | FROM                | TO         |                       |
|   |   | Month/Year          | Month/Year |                       |
|   |   |                     |            |                       |
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|   |   |                     |            |                       |

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

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



NAME (Last, First, MI):

SS#:

Profession:

**PART IV: Record of Licensure Information**

If you have ever been licensed to practice the profession for which you are now making application, or held a related license, complete the information requested below. If you have ever held a temporary, trainee or apprenticeship license, or a permit, it must be listed here also. In addition, the INSTRUCTION SHEET enclosed with this Application package may instruct you to have Certification(s) of Licensure in other state(s) prepared and submitted in support of your application (contact other state(s) regarding possible fee). You must also list all other licenses held in Illinois, however, certification of licensure from Illinois is not required. Failure to disclose all licenses held may result in denial of your application or other appropriate action.

| STATE  | PROFESSION NAME | LICENSE NUMBER | DATE OF ISSUANCE | LICENSE STATUS<br>(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<br>(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. <i>If yes, 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.</i>  |  |     |    |
| 2. Have you been convicted of a felony?  |  |     |    |
| 3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>   |  |     |    |
| 4. Have you had or do you now have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i> |  |     |    |
| 5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>   |  |     |    |
| 6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>  |  |     |    |

**PART VII: 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.

**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.

|             |  |                             |  |                    |
|-------------|--|-----------------------------|--|--------------------|
| <b>SEAL</b> |  | Print Name                  |  | Signature          |
|             |  | Title                       |  | Date               |
|             |  | Agency/Board Street Address |  | Area Code (      ) |
|             |  | City, State, ZIP Code       |  | Telephone Number   |

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

**Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.**

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is 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<br>LAST                      FIRST                      MIDDLE | 2. DATE OF BIRTH<br>____ / ____ / ____<br>Month    Day                      Year   | 3. SOCIAL SECURITY NUMBER<br>- - - - -<br>- - - - -<br>- - - - - |
| 4. ADDRESS<br>STREET, CITY, STATE, ZIP CODE                            | 5. PROFESSION NAME AND CODE.<br><br><b>Visiting Professor Physician</b><br>_____<br>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.

SEAL

\_\_\_\_\_  
Signature of Dean

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Dean

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.

**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<br>____/____/____<br>Month Day Year  |  | 3. SOCIAL SECURITY NUMBER<br>____-____-____  |  |
| 4. ADDRESS STREET, CITY, STATE, ZIP CODE |  |  |  | 5. PROFESSION NAME AND CODE.<br><br><b>Visiting Professor Physician</b><br>_____<br>Profession Name Profession Code |  |  |  |
| 6. MAIDEN OR GIVEN SURNAME               |  |  |  | 7. TYPE OF PERMIT<br>[ ]Original<br>[ ]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<br>From ____/____/____ To ____/____/____<br>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

NAME (Last, First, MI):

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 |
|----------------------------|---------|---------------|
|                            |         |               |
|                            |         |               |
|                            |         |               |
|                            |         |               |
|                            |         |               |

SS#:

Profession:

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.

SEAL

\_\_\_\_\_ Date

\_\_\_\_\_ Signature of Dean

\_\_\_\_\_ Print or Type Name of Dean