Instruction Sheet
Physician – Licensure by Acceptance of Examination
Physician – Licensure by Endorsement

Introduction

These instructions cover the basic requirements and procedures to follow for applying for a license as a physician to practice medicine in Illinois. These instructions cover licensure requirements for endorsement and acceptance of examination applicants only. If you are applying on the basis of endorsement you **MUST BE** currently licensed to practice medicine in all of its branches in another jurisdiction. DO NOT use this application packet if you wish to apply for the USMLE Step 3 examination or restoration.

- Contact the Department of Financial and Professional Regulation at 800/560-6420 if you need a restoration application packet.

- Contact the Federation of State Medical Boards (FSMB) at 817/868-4041 or at www.fsmb.org for information on how to apply for USMLE Step 3.

Contents

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

ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

AUTHORIZATION FOR THIRD PARTY CONTACT

Instructions to Applicant: Use this form to authorize individuals or companies (such as employers or credential services) to contact the Department on your behalf regarding your application.

Name:	Phone:
Address:	SSN:
Profession:	Email:

I, _____, hereby authorize the following person/business to communicate with the Division regarding my application for initial licensure. I understand that information received from the person or business listed below shall be binding and that I will be responsible for the accuracy of all information and documents received as part of my application for initial licensure. This authorization shall expire upon issuance of the license, referral to enforcement or expiration of the application.

Name of authorized representative:
Address:
Phone:
Email:

_____ _____

Applicant Signature Date

Completed forms may be sent to the Division at:

fpr.medicalunit@illinois.gov

General Requirements

To be licensed in Illinois you must:

- Be of good moral character
- Meet educational, examination and experience requirements
- Report your U.S. social security number

Send the four-page application for licensure, along with the appropriate fee, and all other applicable forms to the Illinois Department of Financial and Professional Regulation.

Select method of application and complete that area as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Physician	036	Acceptance of Exam	$500.00
Physician	036	Endorsement	$500.00

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.

Fees

The licensure fee for Physician and Surgeon is $500. Fees paid to the Department are **NOT REFUNDABLE.**

- Do not send cash.
- Make your check or money order payable to the Illinois Department of Financial and Professional Regulation.
- Mail the completed application, additional required supporting documents and fee to:

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

You will have to pay additional fees, charged by the providers, for:

- Administration of examinations
- Use of the Federation Credentials Verification Service (FCVS)
- ECFMG certification reports
- Examination scores/reports
- Certifications of Licensure

PERSONAL HISTORY INFORMATION INSTRUCTIONS

On page 4 of the Application for Licensure/Examination (which all applicants are required to complete), Part VI contains a series of personal history questions. These questions must be answered with either "yes" or "no." If any of your responses to numbers 1 through 6 are "yes", submit the following documentation:

Question 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.

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.

Supporting Document PH (Personal History Information) must be completed, signed and dated.

REQUIREMENTS FOR LICENSURE AS A PHYSICIAN AND SURGEON IN ILLINOIS

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

Education Requirements

To satisfy the education requirements for licensure as a physician, you must present evidence of the following:

Professional Education
Satisfactory completion of 6-year post-secondary course of study consisting of two (2) academic years of a course of instruction in a college or university and four (4) academic years of medical education. The four (4) academic years of medical education shall consist of two (2) academic years of study in the basic medical sciences and two (2) academic years of study in the clinical sciences while enrolled in the medical college that conferred the degree (an academic year is defined as a minimum of nine (9) months in length): or graduated from a medical or osteopathic college accredited by the Liaison Committee on Medical Education or the American Osteopathic Bureau on Professional Education.

Endorsement applicants licensed in another jurisdiction prior to January 1, 1988 must meet the above criteria or be a graduate of a foreign medical education program that was considered approved by the Illinois Department of Financial and Professional Regulation on or before December 31, 1987.

Graduates of Foreign Medical Colleges must submit the following documents:

- Verification of ECFMG certification
- Certification of Education (**ED-NON** form)

Experience Requirements

Postgraduate Training Requirements
Satisfactory completion of twelve (12) months of approved training is required if you entered the postgraduate residency training program December 31, 1987, or before; twenty-four (24) months is required if you entered the program January 1, 1988, or after. All training must have been completed in an approved training facility in the U.S. or Canada.

Professional Capacity
ALL applicants who have NOT been engaged in the active practice of medicine or who have NOT been enrolled in a medical program for two (2) or more years prior to application must also submit documentation of Professional Capacity. (See Professional Capacity activities on Page 12.)

Examination Requirements

The current examinations required for licensure as a physician in Illinois are either:

- Step 1, Step 2, and Step 3 of the United States Medical Licensing Examination (USMLE)

OR

- Part I, Part II, and Part III of the examinations of the National Board of Osteopathic Medical Examiners (NBOME)

OR

- Licentiate of the Medical Council of Canada examination (LMCC)

However, if you have completed one of the following combinations of NBME, FLEX, and USMLE examination parts **with scores acceptable to Illinois**, you can satisfy the examination requirement by having the appropriate testing body send your scores to the Illinois Department of Financial and Professional Regulation.

Acceptable Examination Combinations for Medical License if completed prior to January 1, 2000	
NBME Part I *plus* NBME Part II *plus* NBME Part III	USMLE Step 1 *plus* USMLE Step 2 *plus* USMLE Step 3
NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* NBME Part III or USMLE Step 3	NBME Part I or USMLE Step 1 *plus* NBME Part II or USMLE Step 2 *plus* FLEX Component 2
FLEX Component 1 *plus* USMLE Part 3	FLEX Component 1, taken prior to January 1, 1995, *plus* FLEX Component 2, taken prior to January 1, 1994

Examination Requirements (cont'd)

Successful completion of the FLEX Component 2, USMLE Step 3, the Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Special Purpose Examination for United States of America (COMSPEX-USA) is required if you took one of the following examinations:

- National Board of Medical Examiners Examination prior to January 1, 1964
- FLEX Examination prior to June 1, 1968
- National Board of Examiners for Osteopathic Physicians and Surgeons prior to June 1, 1973
- LMCC examination prior to May 1, 1970
- State constructed examination

To request a waiver from the clinical examination requirement (SPEX or COMSPEX-USA) one of the following may be submitted:

- Proof of certification by American Specialty Board
- Proof of achievements of special honors or awards
- Proof of publication of articles in recognized and reputable journals
- Proof of writing or participating in writing of textbooks in medicine

VERIFYING YOUR CREDENTIALS

To ensure authenticity of credentials, the Illinois Department of Financial and Professional Regulation requires that your qualifications of licensure be verified independently. Verified credentials may be submitted from the Federation Credentials Verification Service (FCVS) or from each organization where you met the requirement. Following are detailed instructions and requirements for applying for licensure using the Federation Credentials Verification Service (FCVS) and applying for licensure without using the FCVS.

Note: Submission of the FCVS Profile is optional. It is <u>not</u> required for licensure.

FEDERATION CREDENTIALS VERIFICATION SERVICE (FCVS)

The Federation Credentials Verification Service (FCVS) is operated by the <u>Federation of State Medical Boards of the United States, Inc.</u>, a national nonprofit organization that provides services for the state medical and osteopathic licensing authorities in the U.S., Guam, Puerto Rico and the Virgin Islands. Its primary purpose is to provide a centralized, uniform process for state licensing authorities – as well as private, governmental and commercial entities – to obtain a verified, primary source record of a physician's "core" credentials.

By using FCVS to verify your credentials, you will establish a permanent repository of primary source-verified documents. Once your file is established, these documents will be available for your use at any time. The documents that FCVS verifies and stores for you fall into the following categories:

- Identity
- Medical Education
- Examination History (state licensing authorities only)
- Board Action/Disciplinary History
- ECFMG Certification (if applicable)

FCVS will charge you a fee for gathering and forwarding your initial Profile, and only a processing fee for forwarding additional Profiles (called "Subsequent Requests"). Average processing time to collect and forward your initial Profile is approximately 8 weeks (graduates from medical schools outside the U.S. generally take 2-3 weeks longer). Once your permanent file is established, subsequent requests are typically forwarded within 2-3 weeks. We suggest that you contact FCVS at 1-888-ASK-FCVS and discuss the appropriateness of using its services based upon your individual situation.

The Illinois Department of Financial and Professional Regulation accepts Physician Information Profiles compiled by FCVS. See the FCVS Application, for additional information regarding the service and its fees. **If you choose to use FCVS, you must still apply for licensure in Illinois by submitting the Illinois licensure application, licensure fee of $700, and certain other documentation.**

In certain circumstances where direct verification of credentials cannot be accomplished, it will be necessary for the applicant to meet verification procedures as indicated in the following section on verification by the Illinois Department of Financial and Professional Regulation. The Department reserves the right to reject any or all portions of the FCVS documentation.

If your credentials are already on file with FCVS, contact FCVS at 1-888-ASK-FCVS to have them forwarded to the Illinois Department of Financial and Professional Regulation.

APPLICANTS USING FCVS

Applicants using FCVS
Must Submit the Following

- **FCVS Physician Information Profile**
  Complete the FCVS Application and send the required fee to:

  Federation Credentials Verification Service
  400 Fuller Wiser Road, Suite 300
  Euless, Texas 76039

  If your credentials are already on file with FCVS, request FCVS (1-888-ASK-FCVS) to send your Physician Profile to:

  Illinois Department of Financial and Professional Regulation
  ATTN: Division of Professional Regulation
  Medical Licensing Unit
  320 W. Washington St. – 3rd Floor
  Springfield, Illinois 62786.

  Once the FCVS Physician Profile and the Illinois forms indicated below have been received, your application will be evaluated by the Illinois Department of Financial and Professional Regulation. In rare cases, information collected by FCVS may contain discrepancies or remain incomplete. If necessary, Illinois will contact you for clarification or additional information.

U.S. or Canadian Medical School Graduates

- **Illinois 4-page Medical Application Form**
  Complete the appropriate 4-page application. All questions must be answered and your signature must be affixed. In Part VI, Personal History Information, you must answer "yes" or "no." 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 on the application. (See detailed instructions on Page 3.)

Applicants Using FCVS (cont'd)

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

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

- **VE-PC Form (Verification of Employment/Experience--Professional Capacity)**
  This form is to be completed by all applicants. Record your 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 your medical practice since graduation from medical school. 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 13 of this application packet for additional requirements.
- **Illinois Licensure Fee**
- **An official transcript verifying pre-medical education ****
- **Certification of Licensure Form**
  Certification of Licensure form (CT) from the jurisdiction of original and current licensure.

  ** U.S. or Canadian graduates holding a valid, active Illinois Temporary License issued **AFTER APRIL 1, 2012**, do not need to resubmit the items above that have asterisks.

Graduates of Foreign Medical Colleges

- **Illinois 4-page Medical Application Form**
  Complete the appropriate 4-page application. All questions must be answered and your signature must be affixed. In Part VI, Personal History Information, you must answer "yes" or "no." If any of your responses to numbers 1 through 4 are "yes," submit a detailed statement explaining your affirmative response and any and all applicable information as indicated on the application. (See detailed instructions on Page 3.)
- **CCA form**
  Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
- **PH form**
  Supporting Document PH **must** be completed and submitted with each application. Your application will not be processed without completion of this form.

Applicants Using FCVS (cont'd)

- **VE-PC Form (Verification of Employment/Experience--Professional Capacity)**
  This form is to be completed by all applicants. Record your 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 your medical practice since graduation from medical school. 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 13 of this application packet for additional requirements.
- **Illinois Licensure Fee**
- **An official transcript verifying pre-medical education****
- **Certification of Licensure Form****
  Certification of Licensure form (**CT**) from the jurisdiction of original and current licensure.
- **Proof of satisfactory completion of internship or social service, if required for conferral of the degree.****
- Certification of Education (ED-NON) form completed by the Non-LCME accredited medical college with official, original seal and signature.**

  **IF YOU ARE A FOREIGN EDUCATED GRADUATE AND HOLD A VALID, ACTIVE ILLINOIS TEMPORARY LICENSE YOU ARE NOT REQUIRED TO RESUBMIT EDUCATION D O C U - MENTATION.

VERIFICATION BY THE ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

If you are not using FCVS, we must receive evidence of your compliance with each licensure requirement **directly** from the organization where you met the requirement (e.g., testing agency, licensing authority, hospital, employer, etc.).

To assist in the evaluation process, applicants must submit official transcripts issued by the medical college or university with the school seal affixed. You must also submit an 8-1/2 x 11-inch photocopy of any foreign documents. 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. The translator's certifying statement must be submitted with the translation. Subsequent to review, all official foreign documents will be returned via regular mail. If you would like original documents returned other than by regular mail, you must provide a prepaid envelope.

APPLICANTS NOT USING FCVS

U.S. or Canadian Medical School Graduates

Applicants Not Using FCVS Must Submit the Following:

- **Illinois 4-page Medical Application Form**
  Complete the appropriate 4-page application. All questions must be answered and your signature must be affixed. In Part VI, Personal History Information, you must answer "yes' or "no." If any of your

Applicants Not Using FCVS(cont'd)

responses to numbers 1 through 4 are "yes," submit a detailed statement explaining your affirmative response and any and all applicable information as indicated on the application. (See detailed instructions on Page 3.)

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

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

- **VE-PC Form (Verification of Employment/Experience--Professional Capacity)**
  This form is to be completed by all applicants. Record your 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 your medical practice since graduation from medical school. 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 13 of this application packet for additional requirements.

- **Illinois Licensure Fee**

- **An official transcript verifying pre-medical education ****

- **An official medical transcript with the school seal affixed and copy of your medical school diploma ****
  Official transcripts must be submitted from each and every medical school attended.

- **Certification of Licensure Form**
  Certification of Licensure form (**CT**) from the jurisdiction of original and current licensure.

- **Verification of Pass/Fail Examination History (FLEX, National Board, USMLE)**
  Official transcripts of your pass/fail examination history (FLEX, National Board, and USMLE) must be sent directly from the appropriate board(s) or council(s) to this Department. The pass/fail examination history must include the date and results for each examination attempt. (See pages 5 and 6 of this application packet for examination requirements for Illinois licensure.)

- **Certification of Postgraduate Clinical Training**
  Certification of Postgraduate Clinical Training form (**TN-MED**) must be completed by the program director of the postgraduate clinical program (residency) where your training was completed.

  (See page 5 of this application packet for detailed requirements for Illinois licensure.)

  ** U.S. or Canadian graduates holding a valid, active Illinois Temporary License issued **AFTER APRIL 1, 2012**, do not need to resubmit the items above that have asterisks.

Applicants Not Using FCVS (cont'd)

Graduates of Foreign Medical Colleges

- **Illinois 4-page Medical Application Form**
  Complete the appropriate 4-page application. All questions must be answered and your signature must be affixed. In Part VI, Personal History Information, you must answer "yes' or "no." 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 on the application. (See detailed instructions on Page 3.)

  PH form
- Supporting Document PH **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
- **CCA form**
  Supporting Document CCA **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
- **VE-PC Form (Verification of Employment/Experience--Professional Capacity)**
  This form is to be completed by all applicants. Record your 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 your medical practice since graduation from medical school. 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 12 of this application packet for additional requirements.
- **Illinois Licensure Fee**
- **An official transcript verifying pre-medical education****
- **An official medical transcript with the school seal affixed and copy of your medical school diploma****
  Official transcripts must be submitted from each and every medical school attended.
- **Certification of Licensure Form****
  Certification of Licensure form (**CT**) from the jurisdiction of original and current licensure.
- **Proof of satisfactory completion of internship or social service, if required for conferral of the degree.****
- **Verification of Pass/Fail Examination History (FLEX, National Board, USMLE)**
  Official transcripts of your pass/fail examination history (FLEX, National Board, and USMLE) must be sent directly from the appropriate board(s) or council(s) to this Department. The pass/fail examination history must include the date and results for each examination attempt. (See pages 5 and 6 of this application packet for examination requirements for Illinois licensure.)

Applicants Not Using FCVS (cont'd)

- **Certification of Postgraduate Clinical Training**
  Certification of Postgraduate Clinical Training form (**TN-MED**) must be completed by the program director of the postgraduate clinical training program (residency) where your training was completed. (See page 5 of this application packet for detailed requirements for Illinois licensure.)

- **Verification of ECFMG certification****

- Certification of Education form (**ED-NON**) completed by the Non-LCME accredited medical college with official, original seal and signature.**

****IF YOU ARE A FOREIGN EDUCATED GRADUATE AND HOLD A VALID, ACTIVE ILLINOIS TEMPORARY LICENSE YOU ARE NOT REQUIRED TO RESUBMIT EDUCATION DOCUMENTATION.**

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 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, 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.

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 Physicians

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

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 **<u>must</u>** be completed and submitted with each application. Your application will not be processed without completion of this form.	
VE-PC Form	
FCVS Physician Profile (optional)	
TN-MED Form	
ECFMG Certificate (copy)	
Medical School Diploma (copy)	
Proof of Pre-Medical and Medical Education (official transcript of grades issued by college or university with school seal affixed).	
Proof of Name Change (if applicable)	
ED-NON (IMG only)	
5th Pathway/Social Service (if applicable)	
CT (Certification of Licensure) Form from ***original*** and ***current*** state of licensure	
Exam Scores (sent directly from USMLE, FLEX, National Board, LMCC or State Board)	
Criminal Background Check	

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

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

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

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

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

A. Type or print legibly with black ink only.

B. **FEES ARE NOT REFUNDABLE.**

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

PART I: Application Category Information

A. **Check the box indicating the appropriate information regarding your application.** ☐ **Military** ☐ **Military Spouse** ☐ **Not Military** ☐ **Decline to Answer**
Military service member is defined as. "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

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

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

C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

☐ This is the first time I have made application for this profession in Illinois.

☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

☐ Other: _____

☐ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

☐ I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.

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

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO.
		__ __ __ – __ __ – __ __ __ __

4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

__ __ __ __ __ – __ __ __ __

5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY ZIP CODE COUNTY

__ __ __ __ __ – __ __ __ __

6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME

8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH	10. AGE
	__ __ / __ __ / __ __ __ __ (Month / Day / Year)	____ ☐ Female ☐ Male

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED

Work: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Home: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

Fax: (__ __ __) __ __ __ – __ __ __ __ (Area Code)

12. **REQUIRED** E-MAIL ADDRESS

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

NAME (Last, First, MI):

SS#:

Profession:

PART III: Education Information

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

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

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

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

1 2 3 4 5 6 7 8 Graduated? ☐ Yes ☐ No

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

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

INSTITUTION NAME	LOCATION (City and State or Country)	DATES OF ATTENDANCE FROM	DATES OF ATTENDANCE TO	Did You Complete Training?
		Month/Year	Month/Year	☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

NAME (Last, First, MI):

SS#:

Profession:

PART IV: Record of Licensure Information

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

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

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

PART V: Record of Examination

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

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

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

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

PART VII: 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.

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.

HEALTH CARE WORKERS CHARGED WITH *OR* CONVICTED OF CRIMINAL ACTS

SUPPORTING DOCUMENT

CCA

1. NAME LAST FIRST MIDDLE

2. ADDRESS STREET, CITY, STATE, ZIP CODE

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

4. SOCIAL SECURITY NUMBER
__ __ __ - __ __ - __ __ __ __

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

- ☐ Acupuncturists
- ☐ Advanced Practice Registered Nurses
- ☐ Advanced Practice Registered Nurse - Full Practice Authority
- ☐ 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:

	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.

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 EDUCATION NON-LCME ACCREDITED MEDICAL COLLEGE

SUPPORTING DOCUMENT

ED- NON

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE

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

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

☐ Permanent Physician 036

☐ Temporary Physician 125

4. SOCIAL SECURITY NUMBER __ __ __-__ __-__ __ __ __ OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER __ __ __ __ __ __ __ __ __

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 _____

APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THE LINE.

DEAN OF MEDICAL SCHOOL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant or altered, the form <u>will not</u> be accepted. Complete dates in form of month/day/year are required where indicated.

A. NAME OF MEDICAL SCHOOL ADDRESS CITY, STATE COUNTRY/PROVIDENCE

B. DATES OF ATTENDANCE - **EACH YEAR** MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

<u>1st year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>2nd year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>3rd year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>4th year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>5th year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>6th year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

<u>7th year</u>
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

INTERNSHIP YEAR, IF APPLICABLE
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

C. BASIC SCIENCE COURSES

Anatomy
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Physiology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Biochemistry
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Microbiology/Immunology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Pathology
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Pharmacology/Therapeutics
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

Preventative Medicine
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

D. INDICATE LENGTH OF ACADEMIC YEAR _____ MONTHS. DATE MEDICAL DEGREE WAS CONFERRED __ __ / __ __ / __ __ __ __ (Month Day Year)

NAME (Last, First, MI):

SS#:

Profession:

E. CORE CLERKSHIP ROTATIONS.

COMPLETE DATES IN THE FORM OF MONTH/DAY/YEAR ARE REQUIRED. EACH ROTATION MUST BE A MINIMUM OF FOUR (4) WEEKS IN LENGTH AND COMPLETED WHILE ENROLLED IN THE MEDICAL COLLEGE CONFERRING DEGREE. CORE ROTATIONS WILL NOT BE ACCEPTED OR CO-VALIDATED FROM ANOTHER MEDICAL SCHOOL. (MPA Section 11 (A)(2).)

Internal Medicine Rotation
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Pediatrics Rotation
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Obstetrics/Gynecology Rotation
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Surgery Rotation
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

Psychiatry Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

** The 4 week psychiatry core clerkship rotation may be completed as follows: 2 weeks must be completed formally and distinctly in psychiatry as verified by the medical school on this form. The other 2 weeks may be completed in other clinical rotations as verified by the applicant's affidavit. Contact the Division for the *Affidavit of Psychiatry Core Clerkship Rotations* form.

I hereby certify that the information above is true and accurate to the records of this medical college and in accordance with Section 11 (A)(2) of the Medical Practice Act and Section 1285.20 of the Administrative Rules. I further certify that the applicant received a medical degree from and was enrolled in this college at the time the core rotations were completed; that the core clinical clerkship rotations were conducted in the clinical teaching facilities either **owned or operated by this medical college; government owned or operated;** OR **formally affiliated or contracted;** OR **held a verbal affiliation agreement** with this medical college. In the case of a written agreement, it is certified that all affiliation agreements were in full effect at the time of the applicant's rotation and evaluations verifying passage of each core clerkship rotation were submitted by the supervising physician.

SEAL OF COLLEGE

_____
Signature of Dean of Medical College

_____
Print Name of Dean of Medical College

_____
Date Completed

_____
Printed Name of Medical College

RETURN THIS FORM TO APPLICANT

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

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

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

5. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

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

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	G. IF LICENSED BY EXAMINATION, RECORD SCORES
☐ Active ☐ Inactive ☐ Lapsed ☐ Other (Explain) _____ _____ _____	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.

SEAL

Print Name

Title

Agency/Board Street Address

City, State, ZIP Code

Signature

Date

Area 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.

CERTIFICATION OF POSTGRADUATE CLINICAL TRAINING

SUPPORTING DOCUMENT

TN-MED

(DPR)

APPLICANT: ***Complete the applicant section. The remainder of this form must be completed by the postgraduate training program director of the institution at which you completed your training.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.	
6. MAIDEN OR GIVEN SURNAME	_____ Profession Name __ __ __ Profession Code	
7. ILLINOIS TEMPORARY LICENSE NUMBER (If applicable)	8. ISSUANCE DATE	

POSTGRADUATE CLINICAL TRAINING PROGRAM DIRECTOR

Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT.

This is to certify that the above-named applicant satisfactorily completed _____ months of postgraduate clinical training in _____
(Name of Specialty Program)

from _____ to _____ at the following hospital:
MM/DD/YYYY **MM/DD/YYYY**

Hospital: _____

Number and Street: _____

City, State and Zip Code: _____

I further certify that at the time of such training the program was accredited by:

- ☐ the ACGME
- ☐ the AOA
- ☐ the CFPC, RCPSC or FMLAC (Canadian Programs)
- ☐ not accredited in the US or Canada

Name of Postgraduate Clinical Training Program Director: _____

Signature of Postgraduate Clinical Training Program Director: _____

Date of this Certification: _____

Telephone No: _____

University/Hospital
S E A L

(If no seal, attach letter on letterhead stating no seal exists.)

INSTRUCTIONS FOR CONTROLLED SUBSTANCES REGISTRATION

****READ AND FOLLOW INSTRUCTIONS CAREFULLY****

If you hold a non-renewed controlled substances registration, you must reinstate that registration. Do not apply for a new registration.

To expedite the processing of your controlled substances application,
SUBMIT THE APPLICATION AND FEE WITH YOUR PROFESSIONAL APPLICATION.

Every person who prescribes and/or stores and dispenses any controlled substances within the State of Illinois must obtain a license issued by the Department of Financial and Professional Regulation in accordance with the Illinois Controlled Substances Act.

A separate controlled substances registration is required for each place of professional practice or business where controlled substances are stored or dispensed.

1. If you do not properly complete Parts I through VII (front and back) of the application, the application will be returned to you and licensure will be delayed.

2. It is ***mandatory*** that the permanent mailing address and/or business address be a street address. **P.O. boxes are not acceptable. Your Controlled Substances registration must be issued to a street address.**

3. If your professional application is pending, write "pending" in Part IV. A controlled substances registration ***will not*** be issued until your professional license has been issued. A controlled substances registration ***will not*** be issued to individuals holding a temporary license.

4. You ***must*** circle the drug schedules for which you are applying in Part III.

5. You ***must*** complete and submit the CCA Form. Your application will not be processed without completion of this form.

6. Submit the $5 application fee. Make check or money order payable to the Department of Financial and Professional Regulation (IDFPR). **The fee is non-refundable**. Mail the completed application and fee to:

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

A State controlled substances registration is a **prerequisite** for Federal controlled substances registration. The address on your Illinois controlled substances registration must be exactly the same address as your Federal registration. For information concerning Federal registration, you must contact:

Drug Enforcement Administration
230 South Dearborn, Suite 1200
Chicago, Illinois 60604
Telephone: 312/353-7875
Web site: **www.deadiversion.usdoj.gov**

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

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

FOR OFFICIAL USE ONLY

IMPORTANT NOTICE: Completion of this form is required by 720 ILCS 570/1 et. seq. (Illinois Compiled Statutes). Disclosure of information is mandatory. Furnishing by applicant of false or fraudulent information or failure to provide pertinent information constitutes grounds for denying such application or revoking any registration issued pursuant to such application.

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

1. PROFESSION NAME	2. PROFESSION CODE - Check applicable box		3. LICENSURE METHOD	4. FEE
Controlled Substances	☐319 Dentist	☐346 Optometrist	Registration	$5
	☐316 Podiatrist	☐390 Veterinarian		
	☐336 Physician	☐377 APRN-FPA		

PART II: Applicant Identifying Information

1. NAME LAST FIRST MIDDLE

2. TITLE (e.g., M.D., O.D., etc.)

3. UNITED STATES SOCIAL SECURITY NO. ___ - ___ - ____

4. PERMANENT MAILING ADDRESS CITY STATE/COUNTRY ZIP CODE COUNTY

_____ + ____

5. NAME OF BUSINESS AND LOCATION (STREET / CITY / STATE / ZIP CODE) WHERE DRUGS ARE STORED AND CONTROLLED SUBSTANCES REGISTRATION IS TO BE ISSUED

6. EMAIL ADDRESS (REQUIRED)

7. If you will ***not*** be storing or dispensing controlled substances, check the box below. Your license will be issued to your permanent mailing address.

☐ I will ***not*** be storing or dispensing controlled substances, including samples.

8. MAIDEN OR GIVEN SURNAME, OR ANY NAME(S)

9. TELEPHONE NUMBER WHERE YOU MAY BE REACHED DURING THE DAY

Work ( ) _____ **FAX** ( ) _____
Area Code Area Code

Home ( ) _____ **FAX** ( ) _____
Area Code Area Code

PART III: Drug Schedule

Circle the schedules for which you are applying:

II III IV V

PART IV: Professional Activity

Practitioner--Check and complete one of the following:

Professional License Number

- ☐ Dentist 019 - _____
- ☐ Optometrist 046 - _____
- ☐ Physician 036 - _____
- ☐ Podiatrist 016 - _____
- ☐ Veterinarian 090 - _____
- ☐ APN-FP 277 - _____

NAME (Last, First, MI):

SS#:

Profession:

PART V: Personal History Information *(This part must be completed by all Applicants)*	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. *If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.*		
2. Have you been convicted of a felony? *In general, a felony conviction by itself does not usually result in denial of licensure.*		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.		
4. Do you now have any disease or condition that presently limits your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition? *If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.*		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? If yes, attach a detailed explanation.		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? If yes, attach a detailed explanation.		
7. Has your authority to prescribe or dispense controlled substances granted by either the U.S. Drug Enforcement Administration (DEA) or any state/territory of the U.S. (including Illinois) ever been voluntarily or involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended or otherwise disciplined? You must answer yes if any of the above actions are currently pending or if you have withdrawn or failed to proceed with an application for any controlled substances license. If yes, attach a separate sheet with complete and accurate explanation and certified documentation from the appropriate entity regarding the action.		

PART VI: Child Support 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.")

PART VII: Certifying Statement

I hereby apply for an Illinois Controlled Substances Registration in accordance with the Illinois Controlled Substances Act. I certify that I have answered all questions on this application to the best of my knowledge.

Date of Application

Signature of Applicant

I UNDERSTAND THAT 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.

Application must be completed in its entirety.
If not completed, it will be returned to the address noted on front of application.

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	3. SOCIAL SECURITY NUMBER
	__ __ / __ __ / __ __ __ __ Month Day Year	_ _ _ - _ _ - _ _ _ _
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**	
6. MAIDEN OR GIVEN SURNAME	☐**Chiropractic Physician** **0 3 8**	

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: _____