INSTRUCTION SHEET

Physician -- Restoration of Licensure

IMPORTANT NOTICE: These Restoration Instructions apply only to those physicians whose licenses have been on inactive status, or in non-renewed status, 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.

To apply for restoration of your Illinois Physician license, follow each of the steps in the order that they are listed below. 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. FEE IS NON-REFUNDABLE.**

Step I--Application

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

1. Part I-A--Application Category Information--Enter information as shown below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Physician	036	Restoration	*

*See Supporting Document RS for fee amount.

2. Part I-B--Check the box "**Other**" and write "**Restoration**" on the line provided.
3. Part II, Applicant Identifying Information--Enter all applicable information requested.
4. Part III, Education Information--Numbers 1 through 7--Enter all applicable information requested.
5. Part IV, Record of Licensure Information--Indicate in this area any license you held as a Physician or any related license.
6. Part V, Record of Examination--Enter any examinations taken to qualify for physician licensure since receiving your Illinois physician license.
7. Part VI, Personal History Information--You must answer all 6 questions with either a "yes" or "no." Information previously submitted to the Department at the time you made application for your original license or as a result of actions initiated by this Department does NOT have to be resubmitted.
8. Part VII, Examination Coding Information--Not Applicable.
9. Part VIII, Child Support Information--This part must be completed by all applicants.
10. Part IX, Certifying Statement--Read the certifying statement and then sign and date your application.The following documentation must be submitted with the 4-page application.

Step II--Supporting Documentation

1. **RS (Restoration)**--This form must be completed in its entirety. Please note: The fee amount shown in the "Official Use Only" box, is the amount to be entered in Part I-A, box 4, of the Application for Licensure/Examination.

2. **CCA Form--**Supporting Document CCA ***must*** be completed and submitted with your application.

3. **PH Form--**Supporting Document PH ***must*** be completed and submitted with your application.

4. **CT (Certification of Licensure)** form must be submitted by said jurisdiction (board or licensing authority) indicating you were authorized to practice during the term of said active practice.

5. **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 renewal period 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 Physicians," on page 5.)

6. Submit one of the following:

   a. **ED-MED (Certification of Education)**--This form must verify completion of a course of study consisting of 960 classroom hours (1 academic year) which includes no more than 25 clock hours of basic sciences and 40 clock hours of clinical sciences in a college approved by this Department. Such course of study must have been completed within 3 years from the date of application;

   OR

   b. **VE (Verification of Employment/Experience)**--This form must be completed to provide documentation of active practice in another jurisdiction. If private practice, in lieu of **VE** form, submit sworn notarized statement attesting to your active practice in said jurisdiction;

   OR

   c. **TN-MED (Certification of Postgraduate Clinical Training)**--This form must be completed verifying successful completion of an approved postgraduate clinical training program (residency) of at least 12 months in length within 3 years from date of application;

   OR

   d. **DD214**--If restoring after active military service, submit a copy of this form;

   OR

   e. Verification of successful completion of the **Special Purpose Examination (SPEX) or the Comprehensive Osteopathic Medical Special Purpose Examination for the United States of America (COMSPEX-USA)** within 3 years from the date of application. To be successful you must receive a score of 75 or better.

Step III--Fee

See the "Official Use Only" box on the **RS--Restoration** form for the amount you will have to remit to restore your license.

Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation.

Step IV--Mail Application

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

Step V--Need Assistance

If assistance is needed, you may contact the Department in writing or direct your inquiry to the following telephone number:

1-800-560-6420

TTY - 1-866-325-4949

When making an inquiry, state the profession for which you are applying and that you need assistance with your application. Following the mailing of your application, please allow **45 days** before making an inquiry concerning its status.

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.

ADDENDUM

RESTORATION CONTINUING EDUCATION FACT SHEET FOR PHYSICIANS

APPROVED CONTINUING MEDICAL EDUCATION HOURS

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

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

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

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

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

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

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

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

iii) self-assessment activities; and,

iv) journal-based CME.

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

A) Consultation with peers and experts concerning patients;

B) use of electronic databases in patient care;

C) small group discussions;

D) teaching health professionals;

E) medical writing;

F) teleconferences;

G) preceptorships;

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

I) preparation of educational exhibits;

J) journal-readings;

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

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

APPROVED CME SPONSORS

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

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

B) Illinois State Medical Society, or its affiliates;

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

D) Illinois Chiropractic Society, or its affiliates;

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

F) International Chiropractic Association, or its affiliates;

G) American Chiropractic Association, or its affiliates; or

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

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 Physician--Restoration

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

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	
CT (Certification of Licensure) Form from the jurisdiction of current licensure	
RS (Restoration) Form	
CCA and **PH** Forms	
CME Requirement (150 hours)--Copies of certificates verifying a minimum of 60 hours Category I CME and verification of Category II CME (see instructions)	
Submit one of the following: **ED-MED** Form; or **VE** Form; or **TN-MED** Form; or **DD214** ***or*** **SPEX** exam results (see instructions)	

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.illinois.gov

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.)

NAME (Last, First, MI):

SS#:

Profession:

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

PART VII: Examination Coding Information *(This part is for examination applicants only)*

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

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

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

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

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

PART VIII: Child Support and 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 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.

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 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

RESTORATION

SUPPORTING DOCUMENT

RS

APPLICANT: Complete this form, and **return it with your Application for Licensure/Examination.** If additional space is required for recording of information, use the reverse side of this form.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH

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

3. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

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

Profession Name ____ ____ ____ Profession Code

6. MAIDEN OR GIVEN SURNAME

7. NAME AS IT APPEARS ON EXPIRED/INACTIVE LICENSE

8. ISSUANCE DATE OF EXPIRED OR INACTIVE LICENSE

9. DATE EXPIRED OR PLACED INACTIVE

10. EXPIRED OR INACTIVE LICENSE NUMBER

OFFICIAL USE ONLY

License No.: _____ Fees: $ _____

Issuance Date: _____ On CRT: ☐Yes ☐No

11. STATE WHY YOU FAILED TO RENEW YOUR LICENSE.

12. EXPLAIN WHY YOU WANT YOUR LICENSE RESTORED AT THIS TIME.

13. LIST SPECIFIC EDUCATIONAL ACTIVITIES, I.E., COURSES, CONTINUING EDUCATION CLASSES, WORKSHOPS, READING, ETC., DURING THE PAST FIVE YEARS THAT UPDATED YOUR PROFESSIONAL/OCCUPATIONAL KNOWLEDGE.

14. LIST THE STATE(S) AND DATES WHERE YOU HAVE BEEN PRACTICING SINCE YOUR ILLINOIS LICENSE EXPIRED OR WAS PLACED ON INACTIVE STATUS. INCLUDE A BRIEF DESCRIPTION OF DUTIES PERFORMED.

STATE	NAME OF BUSINESS/INSTITUTION	DATES From Mo/Yr	DATES To Mo/Yr	DESCRIPTION OF DUTIES

I do hereby declare that the information contained herein is true and correct.

Date _____ Signature _____

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.

This page intentionally left blank for double-sided printing.

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

NAME (Last, First, MI):

SS#

Profession:

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.

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 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 GRADUATION
(Current Year Graduates of LCME and COCA-Accredited Programs Only)

SUPPORTING DOCUMENT

ED - MED

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

1. NAME LAST FIRST MIDDLE

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

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

4. ADDRESS STREET, CITY, STATE, ZIP CODE

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

6. MAIDEN OR GIVEN SURNAME

_____ ___ ___ ___
Profession Name Profession Code

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

SCHOOL OFFICIAL: Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than **45 days** prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

B. DATES OF ATTENDANCE

Start: __ __ / __ __ / __ __ __ __ (Month Day Year)

End: __ __ / __ __ / __ __ __ __ (Month Day Year)

Degree: _____ MD _____ DO

C.

Applicant will complete all requirements for the medical degree as of __ __ / __ __ / __ __ __ __ (Month Day Year) and will graduate on __ __ / __ __ / __ __ __ __ (Month Day Year) .

When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.

I certify that the information recorded herein is true and correct according to the official records of this institution.

_____
Signature of School Official

SCHOOL

S E A L

_____
Print Name of School Official

_____
Title

_____
Date

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE

SUPPORTING DOCUMENT

VE

APPLICANT: ***Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. You are authorized to photocopy this form as necessary.***

1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year	3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application. _____ Profession Name __ __ __ Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. JOB TITLE OR POSITION APPLICANT HELD	
8. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ To __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year	9. SUPERVISOR NAME	

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

PART I - EMPLOYMENT INFORMATION

A. EMPLOYER NAME		B. BUSINESS / INSTITUTION NAME
C. EMPLOYER REGISTRATION/LICENSE NUMBER	D. STATE OF EMPLOYER REGISTRATION/LICENSE	E. BUSINESS ADDRESS STREET CITY STATE ZIP CODE
F. BUSINESS REGISTRATION/LICENSE NUMBER (If Applicable)	G. STATE OF BUSINESS REGISTRATION/LICENSE	H. BUSINESS TELEPHONE NUMBER Area Code (___ ___ ___) ___ ___ ___-___ ___ ___ ___

PART II - APPLICANT EMPLOYMENT INFORMATION

A. NUMBER OF HOURS WORKED PER WEEK	B. TYPE OF EMPLOYMENT [ ]Full-time [ ]Part-time	C. DATES OF EMPLOYMENT From __ __ /__ __ /__ __ __ __ To __ __ /__ __ /__ __ __ __ Month Day Year Month Day Year

D. RECORD APPLICANT'S POSITION TITLE(S)

E. GIVE BRIEF DESCRIPTION OF DUTIES PERFORMED BY THE APPLICANT.

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

_____
Signature

_____ _____
Date Title

IL486-1348 04/06 (L&T)

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: _____

University/Hospital
S E A L

Telephone No: _____

(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.

Every person who prescribes and/or stores or 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 each drug schedule 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.illinois.gov.

FOR OFFICIAL USE ONLY

APPLICATION FOR STATE CONTROLLED SUBSTANCES REGISTRATION

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

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.illinois.gov/LicenseLookUp/fingerprintlist.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.illinois.gov. 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.illinois.gov 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.