

INSTRUCTION SHEET

FOR MAKING APPLICATION UNDER PROVISIONS OF THE ILLINOIS DENTAL PRACTICE ACT

RESTRICTED FACULTY LICENSE TEMPORARY DENTAL TRAINING LICENSE TEMPORARY PERMIT FOR VISITING DENTIST FOR FREE DENTAL CARE

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

BEFORE COMPLETING THE APPLICATION PACKAGE, read each of the 4 steps below in the order that they are listed, then follow the directions as they apply to you. This will aid you in accurately completing your application and eliminate delay in processing. **THE APPLICATION WHICH YOU SUBMIT IS VALID FOR THREE YEARS FROM DATE OF RECEIPT.**

Step 1. Select the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee, from the chart below and record the information in **Part I** (page one) of the **Application for Licensure and/or Examination**.

Professional Fee	Professional Code	Licensure Method	Application Fee
Restricted Faculty License	136	Nonexamination	\$250.00
Restricted Faculty License	136	Renewal of License	\$150.00
Temporary Dental Training License	018	Nonexamination	\$150.00
Temporary Permit for Visiting Dentist for Free Dental Care	175	Nonexamination	\$100.00

Step 2. Proceed with **Part II** (page one) and complete all applicable information requested on all 4 pages of the **Application for Licensure and/or Examination**.

- NOTE: a) Indicate both Pre-Dental and Dental Education in **PART III**, number 6, on the **Application for Licensure and/or Examination**.
- b) **DO NOT COMPLETE PART VII** (page four) of the **Application for Licensure and/or Examination**.

Step 3. The remainder of this form contains specific instructions for your Licensure Method.

NOTE: All documents in a foreign language that are required to be submitted with an application or for any other purpose in connection with licensure must be accompanied by an original, 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.

Step 4. If needed, call **1-800-560-6420** or (TDD) - **1-866-325-4949** for assistance in completing the application package. Please allow 4 weeks from mailing your application before making an inquiry concerning its status.

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

RESTRICTED FACULTY LICENSE

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

NOTE: In accordance with the provisions outlined in the Dental Practice Act, restricted faculty licenses are valid for a period of three (3) years and may be extended or renewed. The holder of a restricted faculty license may practice general dentistry or in his/her area of specialty, but only in a clinic or office affiliated with the dental school.

1. Supporting Document **CCA** **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document **CT** must be completed by the jurisdiction or country of original licensure and the jurisdiction or country of current licensure where you have most recently been practicing, if applicable. You must direct the licensing agency/board to return completed form **CT** directly to you for inclusion with your application.
3. Supporting Document **DN-TT** must be completed showing applicant has a full-time appointment to teach dentistry at an approved dental school or hospital situated in Illinois. Form must be signed by the Dean of the school or hospital administrator. Direct the school/hospital to return completed form directly to you.
4. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. (See page 1, Step 1.)
5. Forward four-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.

RENEWAL OF RESTRICTED FACULTY LICENSE

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

Application for renewal of a restricted faculty license shall be made on forms supplied by the Department at least 60 days prior to expiration of the license. The application shall include:

1. Supporting Document **CCA** **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Four page Application for Licensure and/or Examination;
3. Supporting Document **DN-TT** completed by the Dean of a dental program or administrator of the hospital indicating the term of the renewal contract, not to exceed three (3) years from the date of the original expiration date. Form should be returned directly to you for inclusion with the application.
4. Supporting Document **CT** must be completed by the jurisdiction of current licensure indicating the current status of the license. You must direct the licensing agency/board to return completed form **CT** directly to you.
5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation (see page 1, Step 1).
6. Forward four-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.

NON-EXAMINATION - TEMPORARY DENTAL TRAINING LICENSE

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

Read the following information and then follow the instructions under which you qualify:

1. You should file your application for licensure upon acceptance into the residency or specialty program.
2. Pursuant to the provisions of the Illinois Dental Practice Act, you will be permitted to practice dentistry prescribed by and incidental to the program for a period of three (3) months from the starting date of the program without licensure when an application, in form and substance acceptable to the Department, has been filed with the Department.

You must file Supporting Document **CA-DEN** to practice prior to the issuance of your license.

3. The authorization to practice will not affect the decision on licensure. The authorization to practice will be terminated upon denial of the application.

NOTE: If you are a graduate of a dental program accredited by the Commission on Dental Accreditation of the American Dental Association follow these instructions only.

1. Supporting Document **CCA** **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document **ED-DEN** must be completed in its entirety by the Dean or Registrar of the dental school from which you graduated. Completed document **must have school seal affixed**. This form must be submitted with your application. **OR** Submit an official transcript.
3. If you wish to pursue a specialty or other advanced clinical education program in an approved dental school or hospital situated in Illinois, or to pursue a program of specialty training in a dental public health agency in Illinois, you may qualify for a temporary training license. Supporting Document **CA-DEN** must be completed verifying you have been accepted or appointed for special/residency training. Direct the Dean/Hospital Administrator of the Specialty or Residency program to forward the completed form to you for inclusion with your application.
4. If you have ever held a license as a dentist or a related license, Supporting Document **CT** must be completed by the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** to you for inclusion with your application.
5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. (See page 1, Step 1.)
6. Forward four-page application, supporting documentation and fee payment to: Illinois Department of Financial and Professional Regulation, ATTN: Division of Professional Regulation, P. O. Box 7007, Springfield, Illinois 62791.

NOTE: If you are a graduate of a dental program that is not approved by the Commission on Dental Accreditation you must follow these instructions.

1. Supporting Document **CCA** **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. Supporting Document **ED-DEN** must be completed in its entirety by the Dean or Registrar of the dental school from which you graduated. Completed document **must have school seal affixed**. This form must be submitted with your application. **OR** Submit an official transcript from your pre-dental and dental college or professional institution **with school seal affixed**.
3. If you wish to pursue a specialty or other advanced clinical education program in an approved dental school or hospital situated in Illinois, or to pursue a program of specialty training in a dental public health agency in Illinois, you may qualify for a temporary training license. Supporting Document **CA-DEN** must be completed verifying you have been accepted or appointed for special/residency training. Direct the Dean/Hospital Administrator of the Specialty or Residency program to forward the completed form to you for inclusion with your application.
4. If you have ever held a license as a dentist or a related license, Supporting Document **CT** must be completed by the jurisdiction of current licensure where you have most recently been practicing. You are authorized to photocopy the form if necessary. You must direct the licensing agency/board to return completed form **CT** **directly** to you for inclusion with your application.
5. Fee payment must be in the form of a check or money order made payable to the Illinois Department of Financial and Professional Regulation. (See page 1, Step 1.)
6. Forward four-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.

NON-EXAMINATION - TEMPORARY PERMIT FOR VISITING DENTIST FOR FREE DENTAL CARE

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

A person seeking a Temporary Permit for Free Dental Care pursuant to Section 19.2 of the Act shall file an application on forms provided by the Division that includes:

1. Certification of licensure in the original jurisdiction and from any jurisdiction where the applicant has been practicing for the last one year.
2. Certification of graduation from a course of instruction in a dental school that meets the minimum education standard of the Division specified in Section 1220.40
3. Certification of a collaborative agreement with an Illinois licensed dentist, including the name and license number of the Illinois licensed collaborating dentist.
4. Completion of Affidavit Form (AF-TVD).
5. Supporting document CCA must be completed and submitted with application. Your application will not be processed without completion of the form.
6. The fee as required under Section 1220.415

LICENSURE METHODS AND DEFINITIONS

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

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

IMPORTANT NOTICE

Elder and Child Abuse Reporting

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

"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 Restricted Faculty License / Temporary Training License

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

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

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS--RESTRICTED FACULTY	SUBMITTED
Application Fee.	
CCA Supporting Document CCA must be completed and submitted with each application. Your application will not be processed without completion of this form.	
DN-TT (Certification of Appointment for Restricted Faculty License) completed by the Dean or hospital administrator for faculty appointment to teach dentistry for which you have been accepted.	
CT (Certification of Licensure) Form completed by the jurisdiction or country of original licensure and the jurisdiction or country of current licensure where you have most recently been practicing.	
SUPPORTING DOCUMENTS--TEMPORARY TRAINING LICENSE	SUBMITTED
Application Fee.	
CCA Supporting Document CCA must be completed and submitted with each application. Your application will not be processed without completion of this form.	
ED-DEN Form with school seal affixed.	
Official transcripts from pre-dental and dental college or professional institution with school seal affixed.	
CA-DEN (Certification of Acceptance for Specialty/Residency Training) completed by the dental school/public health agency/hospital in this State that accepted you for specialty/residency training with seal affixed.	
CT (Certification of Licensure) Form completed by the jurisdiction of current licensure where you have most recently been practicing.	

All supporting documents **may not be required**. Please refer to application instructions for your specific method of licensure.
IL486-1971 (DN-RFL TTL 02/15)

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 \$
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C. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION

- | | |
|---|--|
| <input type="checkbox"/> This is the first time I have made application for this profession in Illinois.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.

<input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

<input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
|---|--|

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

1. NAME LAST FIRST MIDDLE	2. TITLE (e.g., M.D., D.D.S., etc.)	3. UNITED STATES SOCIAL SECURITY NO. ____-____-____
4. PERMANENT MAILING ADDRESS STREET CITY STATE/COUNTRY		ZIP CODE COUNTY ____-____-____
5. BUSINESS ADDRESS STREET CITY STATE/COUNTRY		ZIP CODE COUNTY ____-____-____
6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)		7. MOTHER'S MAIDEN NAME
8. PLACE OF BIRTH CITY STATE/COUNTRY	9. DATE OF BIRTH ____/____/____ Month Day Year	10. AGE ____ <input type="checkbox"/> Female <input type="checkbox"/> Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Work: (____) _____-____ Home: (____) _____-____ (Area Code) (Area Code) Fax: (____) _____-____ Fax: (____) _____-____ (Area Code) (Area Code)		12. REQUIRED E-MAIL ADDRESS

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 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 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 <i>(This part must be completed by all applicants)</i>	YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a 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.</i>		
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>		
3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? <i>If yes, attach a copy of the certificate.</i>		
4. 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? <i>If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.</i>		
5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere? <i>If yes, attach a detailed explanation.</i>		
6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position? <i>If yes, attach a detailed explanation.</i>		

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

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

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

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

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

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

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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 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 _____ _____ / _____ / _____ <small>Month Day Year</small>	2. DATE OF BIRTH	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. <div style="text-align: center;"> _____ <small>Profession Name Profession Code</small> </div>	
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 Financial and Professional Regulation or its designated testing service, the information requested below.
Name of Licensing Agency or Board

Signature _____ Date _____

RETURN COMPLETED FORM TO APPLICANT

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

PART I - CERTIFICATION OF EXAMINATION STATUS

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

Name of Examination Date of Examination

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

PART II - CERTIFICATION OF LICENSURE

A. NAME OF PROFESSION AS IT APPEARS ON LICENSE _____	B. LICENSE NUMBER _____												
C. ISSUANCE DATE OF LICENSE _____	D. EXPIRATION DATE OF LICENSE _____												
E. LICENSURE METHOD <input type="checkbox"/> Examination (Administered in Your State) <input type="checkbox"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> Endorsement of License (State) Acceptance of Examination Results _____ (Administered in Another State) _____													
<input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather _____ <input type="checkbox"/> Credentials _____ <input type="checkbox"/> Other (Describe) _____													
F. CURRENT LICENSURE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	G. IF LICENSED BY EXAMINATION, RECORD SCORES <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 80%;">Type of Examination</td> <td style="width: 20%; text-align: center;">Score</td> </tr> <tr> <td>Written</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Practical</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td colspan="2">Received no Grade Below _____</td> </tr> <tr> <td colspan="2">Examination Period _____ days _____ hours</td> </tr> </table>	Type of Examination	Score	Written	_____	Practical	_____	Other (Describe) _____	_____	Received no Grade Below _____		Examination Period _____ days _____ hours	
Type of Examination	Score												
Written	_____												
Practical	_____												
Other (Describe) _____	_____												
Received no Grade Below _____													
Examination Period _____ days _____ hours													

PART III - CERTIFICATION OF EXAMINATION SCORES

A1. National or other Profession Specific Examination
(Record all available information)

Date of Examination _____

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

PART IV - FORMAL ACTIONS

- A. Is there now or has there ever been any formal action commenced against the applicant? Yes No
- B. Have there ever been any formal sanctions imposed against the applicant as a matter of public record including but not limited to fine, reprimand, probation, censure, revocation, suspension, surrender, restriction or limitation? (If yes, attach a certified copy of disciplinary action.) Yes No

PART V - RECIPROCAL REGISTRATION

This state does does not grant the same privilege of reciprocal registration to Illinois registrants.

I certify that the information contained herein is true and correct according to the official records of the State.

S E A L		Print Name		Signature
		Title		Date
		Agency/Board Street Address		Area Code ()
		City, State, ZIP Code		Telephone Number

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

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 25/1 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 ACCEPTANCE FOR
SPECIALTY/RESIDENCY TRAINING**

SUPPORTING DOCUMENT

CA-DEN

NOTE: *An applicant who has filed an Application for Licensure and/or Examination with the Department and has met all requirements for licensure will be permitted to practice dentistry for a period of 3 months from the starting date of the program, unless authorized in writing by the Department to continue such practice for a period specified in writing by the Department. The authority to practice shall terminate immediately upon: (1) the decision of the Department that the applicant has failed the examination; or (2) denial of licensure by the Department; or (3) withdrawal of the application.*

APPLICANT: Complete the applicant section of this form, then forward it to the dental school/public health agency/hospital that has accepted you for specialty/residency training, for completion of the remainder of the form.

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

ADMINISTRATOR: Complete the remainder of this form, then return the form to the applicant.

A. DENTAL SCHOOL/HOSPITAL/INSTITUTION NAME	B. BEGINNING DATE ____ / ____ / ____ Month Day Year	
C. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE	D. ENDING DATE ____ / ____ / ____ Month Day Year	
E. BUSINESS TELEPHONE NUMBER Area Code (____) ____ - ____ - ____	F. SPECIALTY/RESIDENCY NAME	G. YEAR OF POSTGRADUATE TRAINING

I do hereby declare that the above-named applicant has been accepted or appointed for specialty/residency training as indicated above. Upon notification that the applicant has failed the examination; or licensure is denied by the Department; or the application is withdrawn, I understand the authority to practice shall terminate immediately.

SEAL

Signature of Dean/Hospital Administrator

Print Name of Dean/Hospital Administrator

Title

Date

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for double-sided printing.**

NAME (Last, First, MI):

SS#:

Profession:

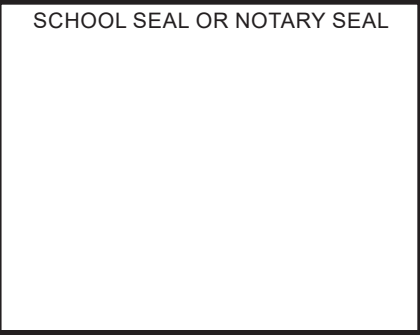
I certify that the information recorded herein is true and correct according to the official records of this institution. I also certify that the applicant has achieved the same level of scientific knowledge and clinical competence as required of all graduates of this institution.

Print Name of School Official

Signature of School Official

Title

Date



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

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

Date of Expiration

Signature of Notary Public

RETURN THIS FORM TO APPLICANT

Notice of Delegated Authority with an Illinois Licensed Dentist

COLLABORATING ILLINOIS LICENSED DENTIST:

Complete this form as official notification you have a collaborative agreement with the applicant.

Submit form to:

**Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
320 West Washington, 3rd Floor
Springfield, Illinois 62786**

1. NAME OF APPLICANT (Last, First, Middle Initial)	2. DATE OF BIRTH ___ / ___ / ___ <small>Month Day Year</small>	3. SOCIAL SECURITY NUMBER - - - - - <small>- - - - -</small>
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. LICENSE NUMBER OF APPLICANT (If unknown, leave blank.)	
6. MAIDEN OR GIVEN SURNAME	7. CURRENT STATE OF LICENSURE	

This is to certify that I, _____, have delegated
(Collaborating Dentist)
 authority to _____ in order to train in the State of Illinois.
(Applicant Name)

 Print Name of Licensed Illinois Dentist

 Signature of Licensed Illinois Dentist

 Illinois License Number of Dentist

 Date of Authority
 (License expires 6 months after this date)

 Business Street Address of Licensed Illinois Dentist

 City, State, Zip Code

Additional forms can be downloaded from the IDFPR Web site at www.idfpr.illinois.gov.

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for double-sided printing.**

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.

**AFFIDAVIT
OF
VISITING DENTIST**

SUPPORTING DOCUMENT

AF-TVD

APPLICANT: Complete the applicant section 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

6. MAIDEN OR GIVEN SURNAME

I certify I am going to receive clinical training from:

Name of CE Sponsor

License Number of CE Sponsor

I certify I received an invitation for clinical training with:

Name of CE Sponsor

License Number of CE Sponsor

Signature of Applicant

Date