

# INSTRUCTION SHEET

## Visiting Physician 180-Day Permit Limited Visiting Physician 5-Day Permit

BEFORE COMPLETING THE APPLICATION PACKAGE, read and then follow all directions. This will aid you in accurately completing your application and thus, eliminate any delay in processing. If approved, a visiting physician permit shall be valid for 180 days or until such time as the clinical studies or techniques are completed, whichever occurs first. A limited permit may be issued to perform an emergency procedure in Illinois for not more than 5 days.

### APPLICATION FOR LICENSURE AND/OR EXAMINATION

Complete the four-page Application for Licensure and/or Examinations follows:

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

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Visiting Physician Permit	106	Non-Examination	\$100
Limited Visiting Physician Permit	106	Non-Examination	\$ 25

**~For Assistance~**  
Call the Department of  
Financial and Professional  
Regulation at one of the  
following numbers and  
state that you are applying  
for a Permit as a Visiting  
Physician and need help  
with your application:  
**800-560-6420**  
**TDD - 217-524-6735**

2. Part I-B--Check the box indicating the appropriate information regarding your application.
3. Part II--Applicant Identifying Information--Enter all applicable information requested. On number 3, Social Security Number is mandatory.
4. Part III--Education Information
  - a. Numbers 1 through 5--Enter all applicable information requested.
  - b. Number 6--Indicate all postsecondary education since graduation from high school. Please indicate beginning and ending dates by month and year.
5. Part IV--Record of Licensure Information--Indicate any license, registration, permit or authorization in the United States, Canada, foreign country, territory or province.
6. Part V--Record of Examination--List all examinations taken; i.e. state constructed, FLEX USMLE National Boards.

7. Part VI--Personal History Instructions--Must be completed by all applicants. If any of your responses to questions 1 through 6 is "yes," submit a detailed statement explaining your affirmative response and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

Question 1--A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s), if probation given, verification that probation was completed satisfactorily, a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

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

Question 2--A report from any and all physicians, counselors, or therapists from whom you are currently receiving treatment for this disease, impairment, or condition. The report must include dates of treatment, method of treatment, diagnosis, and prognosis.

Submit a copy of each of your treating physician's curriculum vitae and verification of board certification if board certified in a Specialty.

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

Question 3--A detailed explanation is required if you have been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way in Illinois or elsewhere. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 4--If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to the Department, any and all information relative to your discharge.

8. Part VII--Do not complete this part.
9. Part VIII--Must be completed by all applicants.
10. Part IX--Read the certifying statement and then sign and date your application.

**180 DAY PERMIT**

You must submit the following with the properly completed 4-page Application for Licensure and/or Examination:

1. **CT** (Certification of Licensure) from the jurisdiction of current licensure indicating the date of issuance and current status of license.
2. **MD-VPH** (Certification of Invitation/Appointment) Form is to be completed by the dean or program director of the school or hospital. Official seal must affixed to the form.
3. Copy of the applicant's current curriculum vitae; and
4. The \$100 fee made payable to the Department of Financial and Professional Regulation.

**LIMITED 5-DAY PERMIT**

You must submit the following with the properly completed 4-page Application for Licensure and/or Examination:

1. Verification of licensure from the jurisdiction of current licensure indicating the date of issuance and current status of license. This form may be faxed directly from the licensing entity to the Department in order to expedite. The fax number is 217-524-2169. The hard copy verification must be followed up by regular mail.
2. **MD-VPH-LTD** (Certification of Invitation/Appointment) Form is to be completed by the dean or program director of the school or hospital. Official seal must be affixed to the form.
3. Copy of the applicant's current curriculum vitae; and
4. The \$25 fee made payable to the Department of Financial and Professional Regulation.

**MAILING ADDRESS**

This application must be on file a minimum of 60 days prior to the commencement date of the training. Please forward the 4-page application, supporting documentation and fee payment to:

Department of Financial and Professional Regulation  
Division of Professional Regulation  
320 West Washington Street, 3rd Floor  
PO Box 7007  
Springfield, IL 62791

## LICENSURE METHODS AND DEFINITIONS

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

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

# IMPORTANT NOTICE

## Elder and Child Abuse Reporting

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

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"Public Act 91-0244 also requires that if you have reasonable cause to believe a child known to you in your professional capacity may be an abused or neglected child you are required to report such possible neglect or abuse to the **DEPARTMENT OF CHILDREN AND FAMILY SERVICES AT 1-800-25abuse.**"

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Visiting Physician Permit

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

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

FOUR-PAGE APPLICATION REVIEW	COMPLETED
Part I. Application Category Information	
Part II. Applicant Identifying Information	
Part III. Education Information	
Part IV. Record of Licensure Information	
Part V. Record of Examination	
Part VI. Personal History Information	
Part VII. Examination Coding Information (if applicable)	
Part VIII. Child Support and/or Student Loan Information	
Part IX. Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS	SUBMITTED
Application Fee	
CT (Certification of Licensure) Form from jurisdiction of current licensure	
<b>Copy of curriculum vitae (CV)</b>	
<b>MD-VPH Form</b>	
<b>MD-VPH-LTD Form (for limited 5-day permit only)</b>	

**All supporting documents *may not be required*. 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 \$
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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.<br><br><input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.<br><br><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.<br><br><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. <b>REQUIRED</b> 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 G.E.D.?     Yes     No

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

5. COLLEGE OR UNIVERSITY (Circle number of years completed)  
 1 2 3 4 5 6 7 8      Graduated?     Yes     No

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

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

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



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







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:

--	--	--	--	--	--	--	--	--	--

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? <i>If yes, attach a separate sheet with complete and accurate explanation.</i>		
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. <i>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.</i>		
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. <i>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.</i>		
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? <i>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.</i>		
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. <i>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.</i>		

**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

**This page intentionally left blank  
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.

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

SUPPORTING DOCUMENT

# CCA

1. NAME      LAST                      FIRST                      MIDDLE

3. PROFESSIONAL LICENSE NUMBER (if any)

\_\_\_\_\_ - \_\_\_\_\_

2. ADDRESS      STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acupuncturists   | <input type="checkbox"/> Naprapaths   | <input type="checkbox"/> Physician Assistants              |
| <input type="checkbox"/> Advanced Practice Registered Nurses                          | <input type="checkbox"/> Nursing Home Administrators  | <input type="checkbox"/> Podiatrists                       |
| <input type="checkbox"/> Advanced Practice Registered Nurse - Full Practice Authority | <input type="checkbox"/> Occupational Therapists  | <input type="checkbox"/> Professional Counselors           |
| <input type="checkbox"/> Athletic Trainers  | <input type="checkbox"/> Occupational Therapy Assistants  | <input type="checkbox"/> Prosthetists                      |
| <input type="checkbox"/> Audiologists   | <input type="checkbox"/> Optometrists   | <input type="checkbox"/> Registered Nurses                 |
| <input type="checkbox"/> Clinical Psychologists                                       | <input type="checkbox"/> Orthotists   | <input type="checkbox"/> Registered Surgical Assistants    |
| <input type="checkbox"/> Clinical Social Workers                                      | <input type="checkbox"/> Pedorthists  | <input type="checkbox"/> Registered Surgical Technologists |
| <input type="checkbox"/> Dental Hygienists  | <input type="checkbox"/> Perfusionists  | <input type="checkbox"/> Respiratory Care Practitioners    |
| <input type="checkbox"/> Dentists   | <input type="checkbox"/> Pharmacists  | <input type="checkbox"/> Speech Pathologists               |
| <input type="checkbox"/> Genetic Counselors   | <input type="checkbox"/> Physical Therapists  |  |
| <input type="checkbox"/> Licensed Clinical Professional Counselors                    | <input type="checkbox"/> Physical Therapy Assistants  |  |
| <input type="checkbox"/> Licensed Practical Nurses                                    | <input type="checkbox"/> Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.), and Chiropractic Physicians (D.C.) |  |
| <input type="checkbox"/> Licensed Social Workers                                      |   |  |
| <input type="checkbox"/> Marriage and Family Therapists                               |   |  |
| <input type="checkbox"/> Medication Aide  |   |  |

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? *  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? *  | <input type="checkbox"/> | <input type="checkbox"/> |

*If **YES** to any of the above, attach a certified copy of the court records regarding your conviction, the nature of the offense and date of discharge, if applicable, as well as a statement from the probation or parole office.*

### Certification Statement

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

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Email

\_\_\_\_\_  
Date

## \* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

## \* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

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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.

<p>1. NAME      LAST                  FIRST                  MIDDLE</p> <p>_____ / _____ / _____  Month      Day                  Year</p>	<p>2. DATE OF BIRTH</p>	<p>3. SOCIAL SECURITY NUMBER</p> <p>____ - ____ - ____</p>
<p>4. ADDRESS    STREET, CITY, STATE, ZIP CODE</p> <p>_____</p>	<p>5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.</p> <p style="text-align: center;">_____                  _____  Profession Name                  Profession Code</p>	
<p>6. MAIDEN OR GIVEN SURNAME</p> <p>_____</p>	<p>7. APPLICANT TELEPHONE NUMBER (Daytime)</p> <p>Area Code ( _____ ) _____ - _____</p>	
<p>8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)</p> <p>_____</p>	<p>8b. LICENSE NUMBER (If applicable)</p> <p>_____</p>	<p>8c. ISSUANCE DATE OF LICENSE (If applicable)</p> <p>_____</p>

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**

<p>A. NAME OF PROFESSION AS IT APPEARS ON LICENSE</p> <p>_____</p>	<p>B. LICENSE NUMBER</p> <p>_____</p>
<p>C. ISSUANCE DATE OF LICENSE</p> <p>_____</p>	<p>D. EXPIRATION DATE OF LICENSE</p> <p>_____</p>
<p>E. LICENSURE METHOD</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><input type="checkbox"/> Examination (Administered in Your State)</p> <p style="margin-left: 20px;"><input type="checkbox"/> National (Name) _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> State Constructed _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Other (Name) _____</p> <p><input type="checkbox"/> Endorsement of License (State)</p> <p style="margin-left: 20px;">Acceptance of Examination Results _____</p> <p style="margin-left: 20px;">(Administered in Another State)</p> </div> <div style="width: 45%;"> <p><input type="checkbox"/> Reciprocity with (State) _____</p> <p><input type="checkbox"/> Waiver/Grandfather</p> <p><input type="checkbox"/> Credentials</p> <p><input type="checkbox"/> Other (Describe) _____</p> </div> </div>	

<p>F. CURRENT LICENSURE STATUS</p> <p><input type="checkbox"/> Active</p> <p><input type="checkbox"/> Inactive</p> <p><input type="checkbox"/> Lapsed</p> <p><input type="checkbox"/> Other (Explain) _____</p> <p>_____</p> <p>_____</p>	<p>G. IF LICENSED BY EXAMINATION, RECORD SCORES</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%;">Type of Examination</td> <td style="width: 30%;">Score</td> </tr> <tr> <td>Written</td> <td>_____</td> </tr> <tr> <td>Practical</td> <td>_____</td> </tr> <tr> <td>Other (Describe) _____</td> <td>_____</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.

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

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

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

**NAME (Last, First, MI):**

**SS#:**

**Profession:**

<p><b>IMPORTANT NOTICE:</b> 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.</p>	<p><b>CERTIFICATION OF INVITATION/APPOINTMENT FOR VISITING PHYSICIAN 180-DAY PERMIT</b></p>	<p>SUPPORTING DOCUMENT</p> <p><b>MD-VPH</b></p>
<p><b>NOTE:</b> An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.</p> <p>A Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, shall be valid for 180 days from the date of issuance or until the time the medical, osteopathic, chiropractic, or clinical studies or techniques are completed, whichever occurs first. The applicant may be required to appear before the Board for an interview prior to, and as a requirement for, the issuance of such visiting physician permit.</p>		
<p><b>APPLICANT: Complete the applicant section of this form. Forward the form to the dean or program director of the school or hospital at which the invitation/appointment has been established. Return the completed form with the Application for Licensure/Examination at least 60 days prior to the beginning date of the invitation/appointment.</b></p>		
<p>1. NAME LAST FIRST MIDDLE</p>	<p>2. DATE OF BIRTH</p> <p style="text-align:center;">           ___ / ___ / ___            Month Day Year         </p>	<p>3. SOCIAL SECURITY NUMBER</p> <p style="text-align:center;">           - - - - -            - - - - -         </p>
<p>4. ADDRESS STREET, CITY, STATE, ZIP CODE</p>	<p>5. MAIDEN OR GIVEN SURNAME</p>	
<p style="text-align:center;"><b>Visiting Physician Permit</b></p> <p style="text-align:center;">Profession Name</p>		<p style="text-align:center;"><b>1 0 6</b></p> <p style="text-align:center;">Profession Code</p>
<p><b>DEAN OR PROGRAM DIRECTOR OF SCHOOL OR HOSPITAL: Complete the remainder of this form, then return the form to the applicant.</b></p>		
<p>A. NAME OF MEDICAL, OSTEOPATHIC, CHIROPRACTIC SCHOOL OR HOSPITAL</p>	<p>B. THE TERM OF CONTRACT NOT TO EXCEED 180 DAYS</p> <p>From ___ / ___ / ___ To ___ / ___ / ___            Month Day Year Month Day Year</p>	
<p>C. NAME OF DEPARTMENT OF SCHOOL OR HOSPITAL</p>	<p>D. TELEPHONE NUMBER (Include Area Code)</p>	
<p>E. LOCATION OF SCHOOL OR HOSPITAL (Street, City, State, Zip Code)</p>	<p>F. FAX NUMBER (Include Area Code)</p>	
<p>G. DESCRIBE IN DETAIL THE NATURE OF CLINICAL SUBJECT OR TECHNIQUE THAT APPLICANT HAS BEEN INVITED/APPOINTED TO STUDY, DEMONSTRATE, OR PERFORM.</p>		
<p>I do hereby declare that the above-named applicant has been invited/appointed to study, demonstrate or perform a specific clinical subject or technique as a visiting physician for 180 days or until such time as the clinical studies or techniques have been completed, whichever occurs first.</p>		
<p><b>S E A L</b></p>	<p style="text-align:center;">_____</p> <p style="text-align:center;">Signature of Dean or Program Director</p>	<p style="text-align:center;">_____</p> <p style="text-align:center;">Print or Type Name of Dean or Program Director</p>
<p style="text-align:center;">_____</p> <p style="text-align:center;">Date</p>		

<p><b>IMPORTANT NOTICE:</b> 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.</p>	<p><b>CERTIFICATION OF APPOINTMENT FOR LIMITED VISITING PHYSICIAN 5-DAY PERMIT</b></p>	<p>SUPPORTING DOCUMENT <b>MD-VPH-LTD</b></p>
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**NOTE:** An applicant shall not commence the appointment before the program receives written notification of approval from the Department of Financial and Professional Regulation.

A Limited Visiting Physician Permit issued pursuant to Section 18(B) of the Medical Practice Act, will be issued for no more than 5 days. However, in extenuating circumstances, upon review by the Chairman of the Licensing Board or his/her designee, the permit may be extended.

**APPLICANT: Complete the applicant section of this form. Forward the form to the administrator of the hospital at which the emergency procedure is to be performed. Return the completed form with the Application for Licensure/Examination.**

<p>1. NAME      LAST              FIRST              MIDDLE</p>	<p>2. DATE OF BIRTH</p> <p style="text-align:center;">       ___ / ___ / ___        Month      Day      Year     </p>	<p>3. SOCIAL SECURITY NUMBER</p> <p style="text-align:center;">       - - - - -        - - - - -        - - - - -     </p>
<p>4. ADDRESS STREET, CITY, STATE, ZIP CODE</p>	<p>5. MAIDEN OR GIVEN SURNAME</p>	
<p><b>Limited Visiting Physician Permit</b>    <u>  1  </u> <u>  0  </u> <u>  6  </u></p> <p style="text-align:center;">       Profession Name    Profession Code     </p>		

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

<p>A. NAME OF FACILITY/HOSPITAL WHERE EMERGENCY PROCEDURE IS TO BE PERFORMED</p>	<p>B. EXACT DATE OF PROCEDURE</p> <p style="text-align:center;">       To ___ / ___ / ___        Month      Day      Year     </p>
<p>C. NAME OF DEPARTMENT</p>	<p>D. NAME OF ILLINOIS SPONSORING PHYSICIAN RESPONSIBLE FOR APPLICANT</p>
<p>E. LOCATION OF FACILITY/ HOSPITAL (Street, City, State, Zip Code)</p>	<p>F. LICENSE NUMBER OF ILLINOIS SPONSORING PHYSICIAN RESPONSIBLE FOR APPLICANT</p> <p style="text-align:center;"><b>036 -</b></p>

G. DESCRIPTION OF EMERGENCY PROCEDURE TO BE PERFORMED:

  
  
  
  

We, as the facility/hospital administrator and sponsoring physician, do hereby declare that the above-named applicant has approval from the faculty of this facility/hospital to perform the emergency procedure described above.

\_\_\_\_\_

Date

  

\_\_\_\_\_

Printed Name of Hospital Administrator

  

\_\_\_\_\_

Signature of Hospital Administrator

  

\_\_\_\_\_

Signature of Sponsoring Physician

**S E A L**