Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Reinstatement of Illinois Health Care License- COVID-19

This application is specific to the COVID-19 Pandemic and limited to prior State of Illinois licensees who were in good standing and in the following professions only: Licensed Practical Nurse, Advanced Practice Registered Nurse, Registered Nurse, Physician Assistant and Respiratory Care Practitioner. Your license must have been active and in good standing as of January 1, 2016. License will have an expiration date of 9/30/2020 and a $0.00 fee.

PLEASE TYPE AND SUBMIT ELECTRONICALLY

License No: _____ SSN (Last four only): _____ Date of Birth: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

☐ **CHECK HERE IF NAME OR ADDRESS CHANGE.** A name change must be accompanied by documentary proof. Proof must be one of the following: Marriage Certificate, Divorce Decree, Court Order, or an Officially Issued State ID (Driver's License, Passport).

CHECK THE APPROPRIATE ANSWER BELOW:
Are you more than 30 days delinquent in complying with a child support order? **NOTE:** If you are not subject to a child support order, answer "No".

☐ NO ☐ YES

FITNESS TO PRACTICE: Do you have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community? If yes,attach a detailed statement, including an explanation whether or not you are currently under treatment. ☐ NO ☐ YES

PURSUANT TO 20ILCS 2105-165(a), the Department requires the disclosure of information regarding convictions pertaining to certain offenses for this profession. You must respond to each of the following questions:

1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? ☐ NO ☐ YES

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? ☐ NO ☐ YES

3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act

☐ NO ☐ YES

4) Are you currently charged with or have you been convicted of a forcible felony? ☐ NO ☐ YES

Under penalty of perjury, I declare that I have examined this form and, to the best of my knowledge, all statements are true, correct and complete.

Signature: _____ Date: _____

FOR EXPEDITED REVIEW AND SERVICE, EMAIL COMPLETED FORM TO: fpr.lmu@illinois.gov.