

INSTRUCTION SHEET

PHYSICIAN AND SURGEON

- Temporary Licensure
- Limited Temporary Licensure
- Transfer of Temporary Licensure
- Extension of Temporary Licensure

***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.***

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

EDUCATIONAL REQUIREMENTS

In order to be considered for licensure in Illinois, an applicant must have completed a 6 year postsecondary course of study comprising of:

Preprofessional Education

2-year course of instruction, in a liberal arts or medical college.

Professional Education

Graduation from a medical or osteopathic college officially recognized by the jurisdiction in which it is located for the purpose of receiving a license to practice medicine in all of its branches comprised of:

1. at least 2 academic years of study in the basic medical sciences; and
2. 2 academic years of study in the clinical sciences while enrolled in the medical college which conferred the degree and with the stipulation that the core rotations of which must have been either:
 - a) in clinical teaching facilities owned, operated, or formally affiliated with the medical college which conferred the degree; or
 - b) under contract in teaching facilities owned, operated, or affiliated with another medical college which is officially recognized by the jurisdiction in which the medical school which conferred the degree is located; or
 - c) graduated from a medical or osteopathic college accredited by the Liaison Committee on Medical Education or the American Osteopathic Bureau of Professional Education.

Fifth Pathway

Individuals applying for licensure who studied medicine at a medical or osteopathic college located outside the United States, its territories, or Canada, in addition to meeting the 6 year postsecondary course of study requirement outlined above, except for the awarding of a degree and completion of internship and social service, must submit verification of completion of a "Fifth Pathway" program which is considered approved by the Department.

PROFESSIONAL CAPACITY QUALIFICATIONS

In determining professional capacity, the Department shall consider, **but not be limited to**, the following activities:

Medical Research

Medical research shall be human clinical research that is consistent with the requirements of the Federal Food and Drug Administration, and the Consumer Product Safety Commission.

Special Training or Education

Specialized training or education shall be clinical training or clinical education such as the following:

- a. Clinical training which takes place in a residency training program recognized by the Department.
- b. Clinical medical practice in the National Health Service.
- c. Continuing medical education (CME) recognized by the American Council on Continuing Medical Education (ACCME), the American Osteopathic Association (AOA), or continuing medical education in accordance with the adopted Rules and Regulations of the Department.
- d. Postgraduate education in basic or related medical sciences.

Published

Publication in medical or scientific journals of original work in clinical medicine which are listed by the Cumulative Index Medicus (CIM).

Public Clinical Research

Clinical research or professional clinical medical practice in public health organizations (e.g. World Health Organization (WHO), Malaria Prevention programs, United Nations International Children's Emergency Fund (UNICEF) programs, both national and international.

Federal Clinical Research

Having been engaged in clinical research or clinical medical practice at a veterans, military, or other medical institution operated by the federal government.

Other

Other professional or clinical medical activities such as:

- a. Presentation of papers or participation on panels as a faculty member at a program approved or recognized by the American Medical Association (AMA) or its affiliate, the American Osteopathic Association (AOA) or its affiliate, or a specialty society or equivalent recognized by the medical community;
- b. Experience obtained as a Visiting Professor in accordance with Section 18(a) of the Illinois Medical Practice Act of 1987.

APPLYING FOR LICENSURE

***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.***

GENERAL INSTRUCTIONS

Forward the four-page application, supporting documentation, and fee to:

**Department of Financial and Professional Regulation
ATTN: Division of Professional Regulation
P.O. Box 7199
Springfield, IL 62791**

1. Read these instructions; then read "Filing Instructions for Temporary Licensure," to determine the basis under which you must comply and the documentation and forms you must submit.
2. **All documents in a foreign language** must be accompanied by an original, notarized translation that has been transcribed 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.
3. Read the applicable section of the "Forms Completion Guide" (pages 8 through 10) for information concerning 4-page application and Supporting Documents prior to completing the applicable forms. You may photocopy any of the enclosed forms if additional forms are needed.
4. To determine the fee, consult the Reference Sheet, Chart 1. Fee payment must be in the form of a check or money order made payable to the Department of Financial and Professional Regulation.
5. After receipt and review of the completed application by the Department, if determination of eligibility cannot be made, you will be notified to appear for an interview before the Medical Licensing Board at a regularly scheduled board meeting.
6. The temporary license is issued to the hospital where clinical training is to be undertaken. All inquiries and correspondence **will** be directed to the GME office of the hospital.
7. All applications for temporary, limited, transfer and extension must be on file a minimum of **60 days prior to the commencement date of the training**.
8. If you need any further assistance, please contact the GME office at the hospital.

FILING INSTRUCTIONS FOR TEMPORARY LICENSURE

Temporary Licensure for Individuals who Graduated from Approved U.S. or Canadian Colleges

Graduates of approved U. S. or Canadian colleges, must submit the following in order to be considered for temporary licensure (read the above *General Instructions* before proceeding):

- a. Application for Licensure;
- b. **VE-PC** Verification of Employment/Experience--Professional Capacity;
- c. **CT** Certification of Licensure, if applicable;

FILING INSTRUCTIONS FOR LICENSURE (*cont'd*)

- d. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);
- e. Fee;
- f. An official transcript verifying a minimum of 2 years liberal arts/pre-medical education with school seal affixed;
- g. Submit one of the following to verify medical education:
 - **ED-MED** Certification of Education (current year graduates only);
 - **OFFICIAL ILLINOIS MEDICAL SCHOOL ROSTER**;
 - **MEDICAL SCHOOL TRANSCRIPTS** with school seal affixed and a copy of your medical school diploma if graduation date and degree conferred is not on your transcript.
- h. Individuals who graduated from a medical or osteopathic college more than 2 years prior to date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province in addition to meeting all requirements for licensure, must submit documentation to the department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

Temporary Licensure for Individuals who Graduated from NON-LCME Approved Colleges

Individuals who did not graduate from medical or osteopathic college accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools in conjunction with the Liaison Committee on Medical Education, or the American Osteopathic Bureau on Professional Education must submit the following in order to be considered for temporary licensure (read *General Instructions*, page 4, before proceeding):

- a. Application for Licensure;
- b. **VE-PC** Verification of Employment/Experience--Professional Capacity;
- c. **CT** Certification of Licensure, if applicable;
- d. An official transcript with school seal affixed verifying a minimum of 2 years liberal arts/pre-medical education (see *Educational Requirements*, page 2);
- e. Medical school transcript with school seal affixed (see *Educational Requirements*, page 2);
- f. A copy of your original medical school diploma if graduation date and degree conferred is not on transcript;
- g. **CA-MED** Certification of Acceptance for Specialty/Residency Training (this form must be signed by the residency program director);
- h. **ED-NON** Certification of Education;
- i. Verification of successful completion of either E.C.F.M.G., V.Q.E., or F.M.G.E.M.S.;
- j. **AF-MED** Certification of Affiliation or affidavits (refer to Page 10);

International Medical Graduates

Original transcripts or its equivalent (i.e., statement of marks obtained, academic records of studies, etc.) are necessary for a determination of eligibility standards. You must also provide a photocopy of the documents. Subsequent to review originals will be returned via registered mail.

FILING INSTRUCTIONS FOR LICENSURE (*cont'd*)

- k. Fee;
- l. Individuals graduating from a Fifth Pathway program must submit, in addition to all of the documents requested above, verification of completion of an approved Fifth Pathway program.
- m. Individuals must submit proof of completion of internship or social service if required prior to the granting of their degree.
- n. Individuals who graduated from a medical or osteopathic college more than 2 years prior to the date of application for licensure, not actively engaged in the practice of medicine or engaged in a formal program of medical education in another state, territory, country, or province, in addition to meeting all requirements for licensure, must submit documentation to the Department evidencing professional capacity since graduation from medical school. Refer to page 3 for specific information regarding acceptable documentation to evidence continuing clinical skills.

Transfer of Temporary License

Prior to a new license being issued, the original license must be returned to the Department. A copy of the license may be retained by the hospital.

In order to transfer your temporary license to a different residency training program within the same facility or to another facility, you must submit the following (read *General Instructions*, page 4, before proceeding):

- a. Application for Licensure
- b. Your current temporary license must be returned to the Department by the clinical teaching facility/institution.
- c. **CA-MED** Certification of Acceptance for Speciality/Residency (This form must be signed by the residency program director.)
- d. Fee.

Extension/Reissue of Temporary License

Prior to a new license being issued, the original license must be returned to the Department. A copy of the license may be retained by the hospital.

Temporary licenses may be extended only in the following documented situations: 1) serving full-time in the Armed Forces; 2) an incapacitating illness; 3) continuance of a residency training program in order to meet the remedial requirements to retake the licensure examination, 4) continuance of a residency training program within ACGME or AOA guidelines. **The Department allows for a 14-day extension beyond the expiration of the temporary license without filing an application to extend.** In order to request an extension submit the following (read *General Instructions*, page 4, before proceeding):

- a. Application for Licensure
- b. A letter from the residency program director advising why an extension is being requested;
- c. **CA-MED** Certification of Acceptance for Specialty/Residency (this form must be signed by the residency program director);
- d. Fee.

FILING INSTRUCTIONS FOR LICENSURE (cont'd)

***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.***

**Limited Temporary
License**

To be eligible for a 6-month limited temporary license, an applicant must be enrolled in an approved training program in another state and be accepted in an approved clinical training program in Illinois due to the absence of adequate facilities in the other state. In order to request a limited temporary license, submit the following (read *General Instructions*, page 4, before proceeding):

- a. Application for Licensure;
- b. **CT** Certification of Licensure, if applicable;
- c. **CA-MED** Certification of Acceptance for Specialty/Residency (this form must be signed by the residency program director of the out-of-state program);
- d. **CA-LTD** Certification of Acceptance for a Limited Specialty/Residency Program in Illinois (this form must be signed by the residency program director in Illinois); and
- e. Fee.

FORMS COMPLETION GUIDE

This guide will help you complete the forms needed to apply for licensure. For information regarding the forms which you will be required to submit, refer to the section entitled *Filing Instructions for Temporary Licensure*.

Application for Licensure and/or Examination

Provide all applicable information requested on all four pages of the application. The following will assist you in this endeavor.

1. Part 1-A--Use the Reference Sheet (Chart 1) to record the appropriate Profession Name, 3 digit Profession Code, Licensure Method and Fee.

Part 1-B--Check the box indicating the appropriate information regarding your application.

2. Part II--Enter all applicable information requested.

3. Part III--Education Information.

- a. Numbers 1 through 5--Enter all applicable information requested.
- b. Number 6--Indicate every college, university or medical school attended, along with dates of attendance.
- c. Number 7--Indicate all postgraduate clinical training including specialty/residency/intern/training.

4. Part IV--Record of Licensure Information--Individuals licensed in a U.S. jurisdiction or a foreign country or province must state whether or not they have ever held licensure (either permanent or temporary) to practice as a physician/surgeon.

5. Part V--Record of Examination--List all examinations taken to qualify for physician licensure; i.e., FLEX, National Boards, and USMLE. Each examination attempt and date taken must be shown.

6. Part VI--Personal History Information--You must answer all 6 questions either "yes" or "no." If any of your responses to numbers 1 through 6 are "yes," submit a detailed statement explaining your affirmative response(s) and any and all applicable information as indicated below. Upon completion of your application, further review will be required.

Question 1-2 A certified copy of all court records (other than minor traffic violations) regarding your conviction of a criminal or driving offense in any county, state, circuit or federal court, including a copy of the police report(s); if probation given, verification that probation was completed satisfactorily; a copy of all proceedings regarding the conviction and final disposition of the charge(s) direct from the court(s).

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

Question 3 If you have been issued a Certificate of Relief from Disabilities by the Prisoner Review Board, you must include a copy of the certificate.

FORMS COMPLETION GUIDE *(cont'd)*

Question 4 A report from any and all physicians, counselors, or therapists from whom you have received treatment for any chronic disease or condition (i.e., chemical/alcohol dependency, depression, etc.). The report must include dates of treatment, method of treatment, diagnosis, and prognosis. Attach a detailed statement advising whether you are currently under treatment.

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 have been treated as an inpatient/outpatient at any time for any disease or condition, then it will be necessary for you to have the institution(s) submit, directly to this Department, copies of any and all admitting histories, physicals and discharge summaries for each inpatient/outpatient stay or treatment.

Question 5 A detailed explanation is required if you have been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere. Information from every state licensing board or licensing entity must be submitted regarding discipline, probation, suspension, censure, restriction, limitation, or revocation of your license, permit, work letter, or certificate to practice medicine or denial of your privilege of taking an examination. The information from each and every state must include the statement of charges, ALL proceedings regarding charges, and disposition of the charges.

Question 6 If you have ever been discharged other than honorably from any branch of the armed service, or from any city, county, state, or federal position, request the appropriate entity to forward, directly to this Department, any and all information relative to your discharge.

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

VE-PC Verification of Employment/ Experience--Professional Capacity

This form is to be completed by all applicants. Record your work history chronologically for the five (5) years preceding the date of application beginning with present employment.

FORMS COMPLETION GUIDE (*cont'd*)

CT Certification of Licensure	This document must be completed by the jurisdiction of original licensure and the jurisdiction where you have most recently been practicing. This applies to individuals licensed in a U.S. jurisdiction or foreign country or province. NOTE: You must direct the licensing entity to return the completed form directly to you.
CA-MED Certification of Acceptance for Specialty/Residency Training	This form is to be completed by the program director of the specialty/residency program to which you applied.
ED-MED Certification of Education	Current year graduates of approved U.S. or Canadian medical schools may have the ED-MED form completed by the dean or registrar of the medical school they attended. This form cannot be signed more than 30 days prior to graduation date.
ED-NON Certification of Education	This form must be submitted by applicants who are graduates of a NON-LCME approved medical school. An official of the school must complete this form with all dates in month/day/year format. Core rotations listed in Part F must indicate number of weeks.
AF-MED Certification of Affiliation	<p>Submit only if applying under 6 year post-secondary education requirement. If you completed core clerkship rotations in a clinical teaching facility which was formally affiliated or under contract with the medical college which conferred the degree, you must submit a copy of each affiliation agreement between the medical college which conferred the degree and each clinical teaching facility in which a core clerkship rotation was completed. Further, the affiliation agreement must be substantiated by submission of an evaluation form completed by the supervising physician for each core clerkship rotation completed.</p> <p><i>If a written affiliation agreement did not exist, do not complete the AF-MED form. It will be necessary to submit affidavits signed by the current dean of the medical college and current administrator of each clinical teaching facility which verifies the following:</i></p> <ol style="list-style-type: none">1) that a verbal affiliation agreement existed between the clinical teaching facility and the medical college at the time the core clerkship rotation was completed;2) that the individual was authorized to complete the core clerkship rotation; and3) that the core clerkship rotation was completed satisfactorily. <p>Affidavits must be accompanied by an evaluation form that was completed by the supervising physician for each core clerkship rotation.</p>
CA-LTD Certificate of Acceptance for a Limited Specialty/Residency Program	This form must be completed and signed by the program director of the Illinois specialty/residency training program for which the applicant is applying.

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.**"

REFERENCE SHEET

ALL FEES ARE NONREFUNDABLE

Department reserves the right to change fees if prevailing circumstances necessitate such action.

CHART I - PROFESSION NAME, PROFESSION CODE, LICENSURE METHOD & FEE

<u>PROFESSION NAME</u>	<u>PROFESSION CODE</u>	<u>LICENSURE METHOD</u>	<u>APPLICATION FEE</u>
Temporary Physician Licensure	125	Nonexamination	\$100.00
Temporary Physician Transfer	125	Nonexamination	\$ 20.00
Temporary Physician Extension/Reissue	125	Nonexamination	\$100.00
Limited Temporary Physician Licensure	130	Nonexamination	\$100.00
Limited Temporary Physician Transfer/Reissue	130	Nonexamination	\$ 20.00

CHART II - EXAMINATION CODES AND FEES

NOT APPLICABLE FOR TEMPORARY PHYSICIAN LICENSURE, OR
LIMITED TEMPORARY PHYSICIAN LICENSURE APPLICANTS
ENTER N/A IN PART VII a) OF APPLICATION
FOR LICENSURE AND/OR EXAMINATION

CHART III - EXAMINATION DATES AND LOCATION

NOT APPLICABLE FOR TEMPORARY PHYSICIAN LICENSURE, OR
LIMITED TEMPORARY PHYSICIAN LICENSURE APPLICANTS
ENTER N/A IN PART VII b) OF APPLICATION
FOR LICENSURE AND/OR EXAMINATION

CHART IV - SCHOOL CODES

NOT APPLICABLE FOR TEMPORARY PHYSICIAN LICENSURE, OR
LIMITED TEMPORARY PHYSICIAN LICENSURE APPLICANTS
ENTER N/A IN PART VII c) OF APPLICATION
FOR LICENSURE AND/OR EXAMINATION

*** * * * * REQUEST FOR ASSISTANCE * * * * ***

IF ASSISTANCE IS NEEDED, DIRECT YOUR REQUEST TO THE
GRADUATE MEDICAL EDUCATION OFFICE AT THE HOSPITAL
WHERE YOU ARE ENTERING RESIDENCY/SPECIALTY TRAINING.

Illinois Department of Financial and Professional Regulation

Division of Professional Regulation

Application Checklist for Temporary Physician

*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 (Certificate of Licensure) Form from original and current jurisdictions of licensure	
VE-PC Form	
CA-MED Form	
ECFMG Certificate (copy), if applicable	
Proof of Pre-Medical and Medical Education	
Medical School Diploma (copy), if applicable	
AF-MED Form, if applicable	
ED-NON Form, if applicable	
5th Pathway/Social Service , if applicable	
CA-LTD Form (Limited Temporary License Only)	

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

APPLICATION FOR LICENSURE AND/OR EXAMINATION

FOR OFFICIAL USE ONLY

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. 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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B. 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"/> 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, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language. |
| <input type="checkbox"/> Other: _____ | |

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
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6. MAIDEN, GIVEN SURNAME, OR ANY NAME(S) UNDER WHICH SUPPORTING DOCUMENTS WILL BE SUBMITTED. (SEE INSTRUCTIONS #5 ABOVE)	7. MOTHER'S MAIDEN NAME
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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. PREFERRED e-MAIL ADDRESS(ES) [If available]
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------

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 any criminal offense in any state or in federal court (other than minor traffic violations)? <i>If yes, 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.</i>			
2. Have you been convicted of a felony?			
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. Have you had or do you now 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, i.e., (1) mental or emotional disease or condition; (2) alcohol or other substance abuse; (3) physical disease or condition, that presently interferes with your ability to practice your profession? <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 <i>(This part is for examination applicants only)</i>													
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.	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												
b) CHART III - Select the examination site you desire and enter Test Center Code:	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td> </tr> </table>												
c) CHART IV - Find your School of Graduation and enter school code:	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>												
d) Record the number of times you have taken this exam in Illinois or any other state:	<table border="1"> <tr> <td></td><td></td> </tr> </table>												

PART VIII: Child Support and/or Student Loan Information (Every applicant is required by law to respond to the following questions)	
<p>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.</p> <p>Are you more than 30 days delinquent in complying with a child support order? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><i>(NOTE: If you are not subject to a child support order, answer "no.")</i></p>	
<p>2. In accordance with 20 Illinois Compiled Statutes 2105/2105-(5), "The Department shall deny any license or renewal authorized by the Civil Administrative Code of Illinois to any person who has defaulted on an educational loan or scholarship provided by or guaranteed by the Illinois Student Assistance Commission or any governmental agency of this State; however, the Department may issue a license or renewal if the aforementioned persons have established a satisfactory repayment record as determined by the Illinois Student Assistance Commission or other appropriate governmental agency of this State." (Proof of a satisfactory repayment record must be submitted.)</p> <p>Are you in default on an educational loan or scholarship provided/guaranteed by the Illinois Student Assistance Commission or other governmental agency of this State? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

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
<p>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.</p>	

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

VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

VE-PC

1. NAME LAST FIRST MIDDLE

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

3. ADDRESS STREET, CITY, STATE, ZIP CODE

Profession Code

Permanent Physician License 036

Temporary Physician Training License 125

Chiropractic Physician License 038

4. DATE OF BIRTH

____ / ____ / ____

Month Day Year

5. SOCIAL SECURITY NUMBER

____ - ____ - ____

6. MAIDEN OR GIVEN SURNAME

Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.

A. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From ____ / ____ / ____

Month Day Year

HOURS WORKED PER WEEK

To ____ / ____ / ____

Month Day Year

TYPE OF EMPLOYMENT

Full-time Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF BUSINESS / INSTITUTION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From ____ / ____ / ____

Month Day Year

HOURS WORKED PER WEEK

To ____ / ____ / ____

Month Day Year

TYPE OF EMPLOYMENT

Full-time Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SS#:

Profession:

C. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
D. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
E. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			
F. NAME OF BUSINESS / INSTITUTION		JOB TITLE	
ADDRESS STREET, CITY, STATE, ZIP CODE		DESCRIPTION OF DUTIES PERFORMED	
DATE OF EMPLOYMENT/ATTENDANCE	HOURS WORKED PER WEEK		
From ___ / ___ / ___ Month Day Year	TYPE OF EMPLOYMENT <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
To ___ / ___ / ___ Month Day Year			
TOTAL TIME WORKED (Year/Month)			

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**CERTIFICATE OF ACCEPTANCE
FOR
SPECIALTY/RESIDENCY PROGRAM**

SUPPORTING DOCUMENT

CA-MED

NOTE: An applicant shall not commence specialty/residency training before he or the hospital/institution receives written notice of the approval of his application from the Department of Financial and Professional Regulation.

APPLICANT: Complete the applicant section of this form, then forward it to the hospital/institution 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.	
6. MAIDEN OR GIVEN SURNAME	_____ Profession Name	_____ Profession Code

ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.

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

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

SEAL

Signature of Program Director

Print Name of Program Director

Title

Date