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!

<table>
<thead>
<tr>
<th>FOUR-PAGE APPLICATION REVIEW</th>
<th>COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part I. Application Category Information</td>
<td></td>
</tr>
<tr>
<td>Part II. Applicant Identifying Information</td>
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<tr>
<td>Part III. Education Information</td>
<td></td>
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<tr>
<td>Part IV. Record of Licensure Information</td>
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<tr>
<td>Part V. Record of Examination</td>
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<tr>
<td>Part VI. Personal History Information</td>
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<tr>
<td>Part VII. Examination Coding Information (if applicable)</td>
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<tr>
<td>Part VIII. Child Support and/or Student Loan Information</td>
<td></td>
</tr>
<tr>
<td>Part IX. Certifying Statement–Signed and Dated</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUPPORTING DOCUMENTS</th>
<th>SUBMITTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application Fee</td>
<td></td>
</tr>
<tr>
<td>CT (Certificate of Licensure) Form from original and current jurisdictions of licensure</td>
<td></td>
</tr>
<tr>
<td>VE-PC Form</td>
<td></td>
</tr>
<tr>
<td>CA-MED Form</td>
<td></td>
</tr>
<tr>
<td>ECFMG Certificate (copy), if applicable</td>
<td></td>
</tr>
<tr>
<td>Proof of Pre-Medical and Medical Education</td>
<td></td>
</tr>
<tr>
<td>Medical School Diploma (copy), if applicable</td>
<td></td>
</tr>
<tr>
<td>AF-MED Form, if applicable</td>
<td></td>
</tr>
<tr>
<td>ED-NON Form, if applicable</td>
<td></td>
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<tr>
<td>5th Pathway/Social Service, if applicable</td>
<td></td>
</tr>
<tr>
<td>TEMP-LTD Form (Limited Temporary License Only)</td>
<td></td>
</tr>
</tbody>
</table>

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. SEE REFERENCE SHEET, CHART I, OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4

1. PROFESSION NAME
   TEMPORARY PHYSICIAN LICENSURE

2. PROFESSION CODE
   1 2 5

3. LICENSURE METHOD
   NON EXAMINATION

4. FEE
   $100

B. CHECK BOX INDICATING THE APPROPRIATE INFORMATION REGARDING YOUR APPLICATION
   ☐ This is the first time I have made application for this profession in Illinois.
   ☐ I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.
   ☐ Other:

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
   □ PUBLIC □ JOHN □ Q. □ M. B. B. S

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
   123 ANY STREET
   ANYTOWN COUNTRY 12345

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
   M/M/D/D
   Y Y Y Y

10. AGE
    ☐ Female
    ☐ Male
    25

11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
    Work: (217) 555-1234
    Fax: (____) _______ _______
    Home: (217) 555-5678
    Fax: (____) _______ _______

12. PREFERRED e-MAIL ADDRESS(ES) (If available)
    JOHN@PUBLIC.COM

APPLICATION FOR LICENSURE AND/OR EXAMINATION - Page 1 of 4

Additional application forms can be downloaded from the IDFPR Web site at www.idfpr.com.
**PART III: Education Information**

1. **PRELIMINARY EDUCATION** (Elementary and High School or G.E.D. Circle number of years completed)
   
   1 2 3 4 5 6 7 8 9 10 11 12
   
   Graduated
   
   High School? ☑ Yes ☐ No
   
   Received
   
   OR G.E.D.? ☐ Yes ☐ No

2. **NAME OF LAST PRELIMINARY SCHOOL ATTENDED**
   
   **VERY GOOD COLLEGE**

3. **LAST PRELIMINARY SCHOOL LOCATION**
   
   (City and State)
   
   **CITY, STATE COUNTRY**

4. **DATE OF GRADUATION**
   
   05/2005
   
   Month/Year

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

6. **COLLEGE OR UNIVERSITY NAME**
   
   (Undergraduate and Graduate)
   
   **EXCELLENT MEDICAL COLLEGE**

7. **LOCATION**
   
   (City and State or Country)
   
   **CITY COUNTRY**

8. **DATES OF ATTENDANCE**
   
   FROM | TO
   
   09/2005 | 05/2010

9. **TYPE OF DEGREE EARNED**
   
   **MEDICAL M.B.B.S.**

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

<table>
<thead>
<tr>
<th>INSTITUTION NAME</th>
<th>LOCATION (City and State or Country)</th>
<th>DATES OF ATTENDANCE FROM TO</th>
<th>Did You Complete Training?</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Month/Year</td>
<td>☑ Yes ☐ No</td>
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<td>☑ Yes ☐ No</td>
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<td>☑ Yes ☐ No</td>
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<td>☑ Yes ☐ No</td>
</tr>
</tbody>
</table>
### 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.

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROFESSION NAME</th>
<th>LICENSE NUMBER</th>
<th>DATE OF ISSUANCE</th>
<th>LICENSE STATUS (Active, Lapsed, etc.)</th>
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<tbody>
<tr>
<td>State of Original Licensure</td>
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<td></td>
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<tr>
<td>State of Current Licensure where you most recently have been practicing:</td>
<td><strong>STATE:</strong></td>
<td><strong>COUNTRY:</strong></td>
<td><strong>MEDICAL</strong></td>
<td><strong>06/2010</strong></td>
</tr>
<tr>
<td>Other States of Licensure</td>
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</tbody>
</table>

(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.

<table>
<thead>
<tr>
<th>NAME OF EXAMINATION</th>
<th>STATE</th>
<th>MONTH/YEAR</th>
<th>EXAM RESULTS (Passed, Failed, Absent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>USMLE STEP 1</td>
<td>State</td>
<td>09/2010</td>
<td>PASSED</td>
</tr>
<tr>
<td>USMLE STEP 2 CK</td>
<td>State</td>
<td>12/2010</td>
<td>PASSED</td>
</tr>
<tr>
<td>USMLE STEP 2 CS</td>
<td>State</td>
<td>02/2012</td>
<td>PASSED</td>
</tr>
<tr>
<td>USMLE STEP 3</td>
<td>State</td>
<td>05/2012</td>
<td>PASSED</td>
</tr>
</tbody>
</table>

(If additional space is needed, attach a separate sheet.)
PART VI: Personal History Information  *(This part must be completed by all applicants)*

1. Have you been convicted of any criminal offense in any state or in federal court (other than minor traffic violations)?  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.
   - [ ] Yes  
   - [x] No

2. Have you been convicted of a felony?
   - [x] Yes  
   - [ ] No

3. If yes, have you been issued a Certificate of Relief from Disabilities by the Prisoner Review Board? If yes, attach a copy of the certificate.
   - [x] Yes  
   - [ ] No

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?  If yes, attach a detailed statement, including an explanation whether or not you are currently under treatment.
   - [x] Yes  
   - [ ] No

5. Have you been denied a professional license or permit, or privilege of taking an examination, or had a professional license or permit disciplined in any way by any licensing authority in Illinois or elsewhere?  If yes, attach a detailed explanation.
   - [x] Yes  
   - [ ] No

6. Have you ever been discharged other than honorably from the armed service or from a city, county, state or federal position?  If yes, attach a detailed explanation.
   - [x] Yes  
   - [ ] No

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.
   - [ ] Yes  
   - [ ] No

b) CHART III - Select the examination site you desire and enter Test Center Code:
   - [ ] Yes  
   - [ ] No

c) CHART IV - Find your School of Graduation and enter school code:
   - [ ] Yes  
   - [ ] No

d) Record the number of times you have taken this exam in Illinois or any other state:
   - [ ] Yes  
   - [ ] No

PART VIII: Child Support and/or Student Loan 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.
   - [ ] Yes  
   - [x] No

   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.")
   - [ ] Yes  
   - [x] No

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.)
   - [ ] Yes  
   - [x] No

   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  
   - [x] 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]

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.
**VERIFICATION OF EMPLOYMENT / EXPERIENCE—PROFESSIONAL CAPACITY**

1. NAME
   - LAST: PUBLIC
   - FIRST: JOHN
   - MIDDLE: Q.

3. ADDRESS
   - STREET: ANY STREET
   - CITY: ANYTOWN
   - STATE: XXXX
   - ZIP CODE: XXXXX

4. DATE OF BIRTH
   - MM/DD/YYYY
   - Month: 12
   - Day: 31
   - Year: 2010

5. SOCIAL SECURITY NUMBER
   - __________

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:
   - [ ] Permanent Physician License
   - [X] Temporary Physician Training License
   - [ ] Chiropractic Physician License
   - Profession Code
     - Permanent Physician License: 036
     - Temporary Physician Training License: 125
     - Chiropractic Physician License: 038

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
- GREAT HOSPITAL #1
- ADDRESS
  - STREET: ANY STREET
  - CITY: ANYTOWN
  - STATE: XXXX
  - ZIP CODE: XXXXX

- DATE OF EMPLOYMENT/ATTENDANCE
  - From: 09/01/2010
  - To: 12/31/2010

- HOURS WORKED PER WEEK
  - 20-25

- TYPE OF EMPLOYMENT
  - Full-time

- TOTAL TIME WORKED (Year/Month)
  - 3 MONTHS

- JOB TITLE
  - MEDICAL OFFICER

- DESCRIPTION OF DUTIES PERFORMED
  - WORKED AS A MEDICAL OFFICER ON A VOLUNTARY BASIS IN HEALTH CLINICS
  - PARTICIPATED IN COMMUNITY HEALTH EDUCATION PROGRAMS

### B. NAME OF BUSINESS / INSTITUTION
- GREAT HOSPITAL #2
- ADDRESS
  - STREET: ANY STREET
  - CITY: ANYTOWN
  - STATE: XXXX
  - ZIP CODE: XXXXX

- DATE OF EMPLOYMENT/ATTENDANCE
  - From: 08/01/2009
  - To: 08/31/2010

- HOURS WORKED PER WEEK
  - 20

- TYPE OF EMPLOYMENT
  - Full-time

- TOTAL TIME WORKED (Year/Month)
  - 1 YEAR 1 MONTH

- JOB TITLE
  - MEDICAL OFFICER

- DESCRIPTION OF DUTIES PERFORMED
  - WORKED AS A MEDICAL OFFICER PERFORMING H & P S

---

IL-486-1965 08/06 (MD)
### C. NAME OF BUSINESS / INSTITUTION
**Great Hospital #3**

**NAME OF STREET, CITY, STATE, ZIP CODE**: XXXXX

**DATE OF EMPLOYMENT/ATTENDANCE**
- **From**: 01/01/2008
- **To**: 07/30/2009

**HOURS WORKED PER WEEK**: 25

**TYPE OF EMPLOYMENT**: □ Full-time  □ Part-time

**TOTAL TIME WORKED** (Year/Month): 1 YEAR 6 MONTHS

**JOB TITLE**: Medical Officer

**DESCRIPTION OF DUTIES PERFORMED**: Worked as a Medical Officer

### D. NAME OF BUSINESS / INSTITUTION
**Great Hospital #4**

**NAME OF STREET, CITY, STATE, ZIP CODE**: XXXXX

**DATE OF EMPLOYMENT/ATTENDANCE**
- **From**: 01/01/2008
- **To**: 12/31/2008

**HOURS WORKED PER WEEK**: 10 - 15

**TYPE OF EMPLOYMENT**: □ Full-time  □ Part-time

**TOTAL TIME WORKED** (Year/Month): 1 YEAR

**JOB TITLE**: House Officer

**DESCRIPTION OF DUTIES PERFORMED**: List Job Duties

### E. NAME OF BUSINESS / INSTITUTION
**Great Hospital #5**

**NAME OF STREET, CITY, STATE, ZIP CODE**: XXXXX

**DATE OF EMPLOYMENT/ATTENDANCE**
- **From**: 01/01/2007
- **To**: 12/31/2007

**HOURS WORKED PER WEEK**: 10 - 15

**TYPE OF EMPLOYMENT**: □ Full-time  □ Part-time

**TOTAL TIME WORKED** (Year/Month): 1 YEAR

**JOB TITLE**: House Officer

**DESCRIPTION OF DUTIES PERFORMED**: List Job Duties

### F. NAME OF BUSINESS / INSTITUTION

**ADDRESS**: STREET, CITY, STATE, ZIP CODE

**DATE OF EMPLOYMENT/ATTENDANCE**
- **From**: _____ / _____ / _______
- **To**: _____ / _____ / _______

**HOURS WORKED PER WEEK**: □ Full-time  □ Part-time

**TOTAL TIME WORKED** (Year/Month)

**JOB TITLE**: Medical Officer

**DESCRIPTION OF DUTIES PERFORMED**:
CERTIFICATION BY LICENSING AGENCY / BOARD

APPLICANT: Complete the applicant section of this form then forward this form to the jurisdiction in which you are requesting certification by a licensing agency/board. Contact certifying jurisdiction for appropriate fee. You are authorized to photocopy this form as necessary.

1. NAME LAST FIRST MIDDLE
   PUBLIC    JOHN    

2. DATE OF BIRTH M.M.D.D.Y.Y.Y.Y
   01 01 19XX

3. SOCIAL SECURITY NUMBER
   __________

4. ADDRESS STREET, CITY, STATE, ZIP CODE
   123 ANY STREET ANYTOWN STATE XXXX

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   Temporary Physician Licensure
   Profession Name: Doctor of Medicine
   Profession Code: 125

6. MAIDEN OR GIVEN SURNAME

7. APPLICANT TELEPHONE NUMBER (Daytime)
   Area Code: (217) 555-1234

8a. RECORD PROFESSION NAME AS IT APPEARS ON YOUR LICENSE FROM THE JURISDICTION TO WHICH THIS FORM IS BEING FORWARDED. (If applicable)

8b. LICENSE NUMBER (If applicable)

8c. ISSUANCE DATE OF LICENSE (If applicable)

I hereby authorize GREAT MEDICAL COUNCIL to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.

Signature John Q Public Date mm/dd/yyyy

RETURN COMPLETED FORM TO APPLICANT

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

PART I - CERTIFICATION OF EXAMINATION STATUS
A. The applicant ☐ has written ☐ is scheduled to write the following examination:
   ____________________________________________________________
   ____________________________________________________________
   Name of Examination                                       Date of Examination

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

PART II - CERTIFICATION OF LICENSURE
A. NAME OF PROFESSION AS IT APPEARS ON LICENSE
B. LICENSE NUMBER

C. ISSUANCE DATE OF LICENSE
D. EXPIRATION DATE OF LICENSE

E. LICENSURE METHOD
   ☐ Examination (Administered in Your State)
   ☐ National (Name)
   ☐ State Constructed
   ☐ Other (Name)
   ☐ Endorsement of License (State)
   Acceptance of Examination Results (Administered in Another State)

   ☐ Reciprocity with (State)
   ☐ Waiver/Grandfather
   ☐ Credentials
   ☐ Other (Describe)

F. CURRENT LICENSURE STATUS
   ☐ Active
   ☐ Inactive
   ☐ Lapsed
   ☐ Other (Explain)

G. IF LICENSED BY EXAMINATION, RECORD SCORES
   Type of Examination
   Written
   Practical
   Other (Describe)

   Received no Grade Below

   Examination Period _____ days _____ hours

IL486-0850 04/06 (LT)
CT - Certification by Licensing Agency/Board - Page 1 of 2
PART III - CERTIFICATION OF EXAMINATION SCORES
A1. National or other Profession Specific Examination
   (Record all available information)

<table>
<thead>
<tr>
<th>Scaled Score</th>
<th>Raw Score</th>
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<tr>
<th>Standard Deviation</th>
<th>Corrected Score</th>
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<tr>
<th>National Mean</th>
<th>Percent Score</th>
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A2

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<thead>
<tr>
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<th>DATE</th>
<th>SCORE</th>
<th>SUBJECT</th>
<th>DATE</th>
<th>SCORE</th>
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B. State Constructed Examination

<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DATE</th>
<th>SCORE</th>
<th>SUBJECT</th>
<th>DATE</th>
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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.

Print Name

Title

Agency/Board Street Address

City, State, ZIP Code

Signature

Date

Area Code (   ) Telephone Number

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

Attention Applicant: FOR INCLUSION WITH APPLICATION PACKET.
CERTIFICATION OF EDUCATION
(Current Year Graduates of LCME and COCA-Accredited Programs Only)

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

1. NAME LAST FIRST MIDDLE
   PUBLIC JOHN Q

2. DATE OF BIRTH
   M M / D D / Y Y Y Y

3. SOCIAL SECURITY NUMBER
   ____________________

4. ADDRESS STREET, CITY, STATE, ZIP CODE
   123 Any Street Anytown, State XXXXX

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   TEMPORARY PHYSICIAN LICENSURE
   Profession Name 1 2 5
   Profession Code

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

__________________________
Date

__________________________
Signature

SCHOOL OFFICIAL: Complete the bottom portion of this page and RETURN THIS FORM TO THE APPLICANT.
DO NOT complete this form more than 30 days prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION
   Name: ____________________________________________
   Address: __________________________________________
   City, State, Zip: ____________________________________
   Phone: ____________________________________________
   Fax: ______________________________________________

B. DATES OF ATTENDANCE
   Start: _____ / _____ / _____
   Month Day Year
   End: _____ / _____ / _____
   Month Day Year
   Degree: ______ MD ______ DO

C. CHECK THE APPROPRIATE STATEMENT
   { } Applicant has graduated on _____ / _____ / _____
   Month Day Year
   { } Applicant will complete all requirements for the medical degree as of _____ / _____ / _____ and will
   graduate on _____ / _____ / _____
   Month Day Year

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

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

__________________________________________
Signature of School Official

__________________________________________
Print Name of School Official

__________________________
Title

__________________________
Date

IL486-1426 02/08 (L&T) ED-MED CERTIFICATION OF EDUCATION
CERTIFICATION OF EDUCATION
NON-LCME ACCREDITED
MEDICAL COLLEGE

ED- NON

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.

1. NAME
   LAST  FIRST  MIDDLE
   PUBLIC  JOHN  Q.

2. DATE OF BIRTH
   M M D D Y Y Y Y
   Month  Day  Year

3. SOCIAL SECURITY NUMBER
   ___________

4. ADDRESS
   STREET, CITY, STATE, ZIP CODE
   123 ANY STREET  ANYTOWN  STATE XXXX

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.
   TEMPORARY PHYSICIAN
   LICENSURE
   Profession Name
   Profession Code
   1 2 5

6. MAIDEN OR GIVEN SURNAME

7. NAME OF INSTITUTION ATTENDED
   EXCELLENT MEDICAL COLLEGE

8. DATE OF GRADUATION / COMPLETION
   0 5 / 1 8 / 2 0 1 0
   Month  Day  Year

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

MM/DD/YYYY
Date

Signature of Applicant

APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THIS LINE.

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant, the form will not be accepted.

A. NAME OF INSTITUTION

B. INDICATE DATES OF ATTENDANCE BY YEAR IN MEDICAL SCHOOL. EACH YEAR MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

1st year
From __/__/______ To __/__/______
Month  Day  Year

2nd year
From __/__/______ To __/__/______
Month  Day  Year

3rd year
From __/__/______ To __/__/______
Month  Day  Year

4th year
From __/__/______ To __/__/______
Month  Day  Year

5th year
From __/__/______ To __/__/______
Month  Day  Year

6th year
From __/__/______ To __/__/______
Month  Day  Year

7th year
From __/__/______ To __/__/______
Month  Day  Year

D. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

□ Applicant completed program on __/__/______
   Month  Day  Year

□ Applicant graduated on __/__/______
   Month  Day  Year

If the above dates differ, please attach a letter of explanation.
### E. BASIC SCIENCE COURSES

<table>
<thead>
<tr>
<th>Course</th>
<th>Date Started Month/Day/Year</th>
<th>Date Completed Month/Day/Year</th>
<th>Course</th>
<th>Date Started Month/Day/Year</th>
<th>Date Completed Month/Day/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomy</td>
<td></td>
<td></td>
<td>Pathology</td>
<td></td>
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</tr>
<tr>
<td>Physiology</td>
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<td></td>
<td>Pharmacology</td>
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<tr>
<td>Biochemistry</td>
<td></td>
<td></td>
<td>and Therapeutics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Microbiology-Immunology</td>
<td></td>
<td></td>
<td>Preventative Medicine</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### F. CORE ROTATIONS (e.g. compulsory or basic training)

<table>
<thead>
<tr>
<th>Core Rotations</th>
<th>Date Started Month/Day/Year</th>
<th>Date Completed Month/Day/Year</th>
<th>Total number of WEEKS spent in clinical training on this rotation</th>
<th>Facility Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obstetrics-Gynecology</td>
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<tr>
<td>Pediatrics</td>
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<tr>
<td>Psychiatry</td>
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<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

______________________________  ________________________________
Signature of School Official   Print Name of School Official

______________________________  ________________________________
SCHOOL                         SEAL

______________________________
Title

______________________________
Date

RETURN THIS FORM TO APPLICANT
CERTIFICATION OF AFFILIATION

APPLICANT: Complete the applicant section of this form, then forward it to the appropriate official for completion of A or B.

1. NAME LAST FIRST MIDDLE

PUBLIC JOHN Q

2. DATE OF BIRTH

MM/DD/YYYY

3. SOCIAL SECURITY NUMBER


4. ADDRESS STREET, CITY, STATE, ZIP CODE

123 ANY STREET ANYTOWN STATE XXXXK

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

LICENSEE

125

Profession Name

Profession Code

6. MAIDEN OR GIVEN SURNAME

DEAN OR ADMINISTRATOR OF CLINICAL TEACHING FACILITY

Read A and B below, then complete either A or B and return form to the applicant.

A. MEDICAL COLLEGE: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was owned or operated by the medical college from which he graduated, sign the certification below.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility owned or operated by the medical college from which he graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

_________________________  __________________________
Signature of Dean of Medical College  Name of Medical College

_________________________  __________________________
Type Name of Dean of Medical College  Street Address

_________________________  __________________________
Date  City State Zip Code

B. CLINICAL TEACHING FACILITY: If the clinical teaching facility in which the applicant performed his core clinical rotations (internal medicine, surgery, pediatrics, obstetrics-gynecology, psychiatry) was formally affiliated or contracted with the medical college from which he graduated, sign the certification below. Further, you must submit a copy of the affiliation agreement between the hospital and the medical college which conferred the degree and a copy of an evaluation form for each core clerkship rotation, which was completed by the supervising physician of that rotation.

CERTIFICATION

I hereby certify that the core clinical rotations of the above-named applicant were conducted in a clinical teaching facility formally affiliated or contracted with the medical college from which the applicant graduated and that the applicant was enrolled in the medical college during the course of these core clinical rotations.

_________________________  __________________________
Signature of Administrator of Clinical Teaching Facility  Name of Clinical Teaching Facility

_________________________  __________________________
Type Name of Administrator of Clinical Teaching Facility  Street Address

_________________________  __________________________
Date  City State Zip Code
CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

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
   Public John Q.

2. DATE OF BIRTH Month Day Year

3. SOCIAL SECURITY NUMBER

4. ADDRESS STREET, CITY, STATE, ZIP CODE
   123 Any Street Anytown State XXXYY

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

6. MAIDEN OR GIVEN SURNAME

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

A. HOSPITAL/INSTITUTION NAME
   University of Illinois College of Medicine

B. BEGINNING DATE Month Day Year
   07/01/2012

C. ENDING DATE Month Day Year

D. BUSINESS ADDRESS STREET, CITY, STATE, ZIP CODE
   Carle Forum, IL
   111 West Park Street
   Urbana, IL 61801

E. SPECIALTY/RESIDENCY NAME
   Internal Medicine

F. BUSINESS TELEPHONE NUMBER
   Area Code (217) 383-3110

G. YEAR OF POSTGRADUATE TRAINING
   PGY-1

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.

Signature of Program Director

Print Name of Program Director

Title

Date

SEAL