The following pages include:

Blank Application Materials for you to complete and turn into the state. **(USE BLACK INK ONLY!)**

- 4 PAGE APPLICATION
- HEALTH CARE WORKDERS CHARGED WITH OR CONVICTED OF CRIMINAL ACTS (CCA FORM)
- CERTIFICATION OF EDUCATION FORM (ED) Loyola completes the bottom of this form and returns it back to you.
APPLICATION FOR LICENSURE AND/OR EXAMINATION

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 L OR INSTRUCTIONS PRIOR TO COMPLETING ITEMS 1 THROUGH 4
1. PROFESSION NAME
   Licensed Social Worker
2. PROFESSION CODE
   1 5 0
3. LICENSURE METHOD
   Examination
4. FEE
   $ 50.00

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: ____________________________

   □ My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.

   □ 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
   □ Female □ Male
11. TELEPHONE NUMBER WHERE YOU MAY BE REACHED
   Work: (_______) ______-_______
   Home: (_______) ______-_______
   Fax: (_______) ______-_______
   Fax: (_______) ______-_______
   (Area Code) (Area Code)
12. PREFERRED eMAIL ADDRESS(ES) (IF AVAILABLE)

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**
3. **LAST PRELIMINARY SCHOOL LOCATION**
   - (City and State)

4. **DATE OF GRADUATION**
   - Month ___ Year ___

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

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

7. **SPECIALIZED TRAINING** (Residency, Professional Training, Vocational Training, Practical or Clinical Training)
   - INSTITUTION NAME
   - LOCATION
     - (City and State or Country)
   - DATES OF ATTENDANCE
     - FROM __ __ __ __
     - TO __ __ __ __
   - Did You Complete Training?
     - □ Yes □ No

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**APPLICATION FOR LICENSURE AND/OR EXAMINATION - Page 2 of 4**
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>
</tr>
</thead>
<tbody>
<tr>
<td>State of Original Licensure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State of Current Licensure where you most recently have been practicing.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other States of Licensure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</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></td>
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<td></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.*

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? *If yes, attach a copy of the certificate.*

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.*

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.*

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.*

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**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: **N/A**

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:

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:

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**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 100/10-05(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? *(NOTE: If you are not subject to a child support order, answer "no".)*
   
   Yes [ ] 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.)*

   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 [ ] No [ ]

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**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.
HEALTH CARE WORKERS
CHARGED WITH OR CONVICTED
OF CRIMINAL ACTS

1. NAME
   LAST   FIRST   MIDDLE

2. ADDRESS
   STREET, CITY, STATE, ZIP CODE

3. PROFESSIONAL LICENSE NUMBER (if any)
   ___-___-_____

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.

- Acupuncturists
- Advanced Practice Nurses
- Athletic Trainers
- Audiologists
- Clinical Psychologists
- Clinical Social Workers
- Dental Hygienists
- Dentists
- Genetic Counselors
- Licensed Clinical Professional Counselors
- Licensed Practical Nurses
- Licensed Social Workers
- Marriage and Family Therapists
- Naprapaths
- Nursing Home Administrators
- Occupational Therapists
- Occupational Therapy Assistants
- Optometrists
- Orthotists
- Pedothists
- Perfusionists
- Pharmacists
- Physical Therapists
- Physical Therapy Assistants
- Physicians, including Medical Doctors
- (M.D.), Doctors of Osteopathic Medicine
- (D.O.), and Chiropractic Physicians (D.C.)
- Physician Assistants
- Podiatrists
- Professional Counselors
- Prosthetists
- Registered Nurses
- Registered Surgical Assistants
- Registered Surgical Technologists
- Respiratory Care Practitioners
- Speech Pathologists

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:

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

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?
   ☐ ☐

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

4) Are you currently charged with or have you been convicted of a forcible felony? *
   ☐ ☐

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 __________________________ Date __________________________

IL485-2034  02/13 (crimacts)
**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**

2. **DATE OF BIRTH**
   - Month / Day / Year

3. **SOCIAL SECURITY NUMBER**
   - __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ \n
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**

7. **NAME OF INSTITUTION ATTENDED**

   Loyola University Chicago

   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.

   **SCHOOL OFFICIAL:** Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

   A. **NAME OF INSTITUTION**

   Loyola University Chicago

   B. **ADDRESS OF INSTITUTION**

   STREET, CITY, STATE, ZIP CODE

   820 N. Michigan Ave. Chicago, IL 60611

   C. **DEPARTMENT OF INSTITUTION**

   School of Social Work

   D. **SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT**

   Clinical Social Work

   E. **MAJOR AREA OF STUDY OF THE APPLICANT**

   Social Work

   F. **APPLICANT WAS (CHECK ONE):**

   - [ ] Full-time
   - [ ] Part-time
   - [ ] Co-op

   G. **CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)**

   - [ ] ________ Semester Hours
   - [ ] ________ Quarter Hours
   - [ ] ________ Course Hours

   H. **DATES OF ATTENDANCE**

   From ___ / ___ / ___ ___ ___ ___ To ___ / ___ / ___ ___ ___ ___

   - Month
   - Day
   - Year

   J. **TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)**

   MSW

   K. **DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET**

   ___ / ___ / ___ ___ ___ ___

   - Month
   - Day
   - Year

   L. **DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED**

   ___ / ___ / ___ ___ ___ ___

   - Month
   - Day
   - Year

   M. **CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE**

   - [ ] Applicant has graduated on ___ / ___ / ___ ___ ___ ___
     - Month
     - Day
     - Year

   - [ ] Applicant will graduate on ___ / ___ / ___ ___ ___ ___
     - Month
     - Day
     - Year

   - [ ] Applicant has completed program on ___ / ___ / ___ ___ ___ ___
     - Month
     - Day
     - Year

   - [ ] Applicant will complete program on ___ / ___ / ___ ___ ___ ___
     - Month
     - Day
     - Year

   N. **IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:**

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

Amy Greenberg, LCSW
Print Name of School Official

SCHOOL SEAL OR NOTARY SEAL

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

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

6/17/17
Date of Expiration

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.