**Illinois Department of Financial and Professional Regulation**

**Division of Professional Regulation**

# HEALTH CARE TEMPORARY PRACTICE APPLICATION

# TEM-COV19

**DIRECTIONS:** Only Physicians (MD), Licensed Practical Nurses (LPN), Registered Nurses (RN), Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Respiratory Care Practitioner (RCP), Pharmacists (PH), Dietitian Nutritionists (DN), Clinical Professional Counselors (LCPC), Professional Counselors (LPC), Clinical Psychologists (CP), Physical Therapists (PT), Physical Therapist Assistants (PTA), Clinical Social Workers (LCSW), Social Workers (LSW), Occupational Therapists (OT), & Occupational Therapist Assistants (OTA) may use this form to apply for a Temporary Practice Permit, which will be valid through May 31, 2022 or until the expiration of the Gubernatorial COVID-19 Disaster Proclamation. **Physician applicants ONLY** are required to complete the personal history questions on this form.

PLEASE CHECK THE BOX THAT INDICATES YOUR OUT-OF-STATE LICENSE:

Physician LPN, RN, APRN, PA, RCP, PH, DN, LCPC, LPC, CP, PT, PTA, LCSW, LSW, OT, OTA

## APPLICANT IDENTIFYING INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

SSN: _____ Date of Birth: _____ Profession Name:_____

License Number: _____ License State: _____ License Expiry Date:_____

PURSUANT TO 20ILCS 2105-165(a), THE DEPARTMENT REQUIRES THE DISCLOSURE OF INFORMATION REGARDING CONVICTIONS PERTAINING TO CERTAIN OFFENSES FOR THIS PROFESSION. YOU MUST RESPOND TO EACH OF THE FOLLOWING QUESTIONS:

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

2) Are you currently charged with or have you been convicted of a criminal battery against any patient in the course of patient care or treatment, including any offense based on sexual conduct or sexual penetration? ☐ NO ☐ YES

3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act ☐ NO ☐ YES

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

**PERSONAL HISTORY FOR PHYSICIANS ONLY:** COMPLETION OF THE QUESTIONS BELOW IS NECESSARY TO ACCOMPLISH THE REQUIREMENTS OUTLINED IN 225 ILCS 60 (MEDICAL PRACTICE ACT) OF THE ILLINOIS COMPILED STATUTES. DISCLOSURE OF THIS INFORMATION IS VOLUNTARY. HOWEVER, FAILURE TO COMPLY MAY RESULT IN THIS APPLICATION NOT BEING PROCESSED.

1) Have you ever been disciplined (including but not limited to restricted, suspended, or terminated) by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation. ☐ NO ☐ YES

2) Have you ever resigned in lieu of discipline or while under investigation that could lead to any restriction, suspension, or termination by any hospital or health care entity? If yes, attach a separate sheet with complete and accurate explanation. ☐ NO ☐ YES

3) Have you ever been denied staff membership or privileges in any hospital or health care facility or had such membership or privileges involuntarily reduced, limited, placed on probation, relinquished, denied, revoked or suspended? You must answer yes if any of these actions are currently pending or if you have withdrawn or failed to proceed with an application for privileges/memberships. If yes, attach a separate sheet with complete and accurate explanation AND request the hospital or health care facility to submit a report directly to the Department regarding the action. ☐ NO ☐ YES

4) Has your provider status ever been restricted, suspended or terminated by any insurance carrier, including but not limited to Medicare, Medicaid, Tricare or any private carrier? If yes, attach a separate sheet with complete and accurate explanation. ☐ NO ☐ YES

5) Have you ever voluntarily surrendered a license to practice medicine in any state, country, or U.S. federal jurisdiction? This does not include allowing your license to expire solely due to non-payment of the renewal fee. If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department.
☐ NO ☐ YES

6) Have you ever withdrawn an application for a license to practice medicine or any temporary/resident license in any other state, country, or U.S. federal jurisdiction? If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department. ☐ NO ☐ YES

7) Have you ever been admonished, reprimanded, censured and/or disciplined in any way by any professional or medical society or association or committee thereof, or by any non-licensing governmental agency including but not limited to any governmental assistance agency? (Disciplinary actions include, but are not limited to, any allegations currently pending.) Disclose any stipulation to informal disposition in response to this question. If yes, attach a separate sheet with complete and accurate explanation AND request all official disciplinary documents including initial complaint, stipulations, orders, agreements or reprimands be sent directly to the Department. ☐ NO ☐ YES

8) Do you have any disease or condition that interferes with your ability to perform the essential functions of your profession, including any disease or condition generally regarded as chronic by the medical community, 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. ☐ NO ☐ YES

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: _____ Date: _____

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

***You will receive a Temporary Practice Permit via email.***

***All approved Temporary Practice Permits will have an expiration date of May 31, 2022 or until the expiration of the Gubernatorial COVID-19 Disaster Proclamation and a $0 fee.***

**STATE OF ILLINOIS**
**DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION**
**DIVISION OF PROFESSIONAL REGULATION**

In Re: Health Care Temporary Permit Application of _____ (Applicant)

## AFFIDAVIT OF _____

I, _____ (Affiant), being duly sworn upon oath, depose and make this Affidavit on my personal knowledge, and if sworn as a witness in this matter I would competently testify to the following facts:

1. I am a _____(position title) working for _____(hospital or medical facility) in _____ (city), Illinois. I have held this role for _____(amount of time).

2. Part of my employment duties include reviewing applications for employment and/or credentialing at _____(Hospital) .

3. I reviewed the application for employment of _____(Applicant).

4. I reviewed a report from the National Practitioner Databank dated _____ , for _____(Applicant).

5. _____(Applicant) holds a _____(license type) in _____(State of licensure).

6. Based upon my review of the application for employment and report from the National Practitioner Databank for _____(Applicant), _____(Applicant) has a license in good standing in _____(State of Original Licensure), has no prior disciplinary actions against any license, and has no medical malpractice claims.

Under penalties as provide by law pursuant to Section 1-109 of the Illinois Civil Code of Procedure, I hereby affirm and certify that the statements set forth in this Affidavit are true and correct.
FURTHER AFFIANT SAYETH NOT.

_____ _____
Date Name of Affiant

Subscribed and sworn to before me
this _____ day of _____.

_____
NOTARY PUBLIC

**This form to be completed ONLY by an authorized representative of the hospital or medical facility located in Illinois. Completed affidavit must be submitted to IDFPR with a Health Care Temporary Practice Application within 30 days of execution of the affidavit.**