

# INSTRUCTIONS

**Licensed Social Worker  
or  
Licensed Clinical Social Worker**  
**Non-Examination (LSW ONLY)  
Endorsement  
Acceptance of Examination (LCSW ONLY)  
Examination (LCSW ONLY)  
Restoration**

The requirements of licensure and practice for Illinois Licensed Social Worker (LSW) and Illinois Licensed Clinical Social Worker (LCSW) licensure are provided by the ACT (225 ILCS 20/) and the RULES in Administrative Code (68 IAC Part 1470).

The ACT and RULES are available online at: [www.idfpr.illinois.gov/profs/SocialWorker.html](http://www.idfpr.illinois.gov/profs/SocialWorker.html)

## STEP 1.

Determine the level of license desired. There are two tiers of Illinois Social Worker licensure:

**Licensed Social Worker (LSW)** – Licensed Social Workers must operate at all times under the order, control, and full professional responsibility of a qualified supervisor. The type of license required for a qualified supervisor depends on the type experience being supervised. **Profession Code 150.**

**Licensed Clinical Social Worker (LCSW)** – This is the independent practice level license. **Profession Code 149.**

For more information on roles and responsibilities or scope of practice of each profession, please refer to Sections 3 (Definitions), 4 (Exemptions), 9 (Qualifications), and 10 (License Restrictions and Limitations) of the ACT.

## STEP 2.

There are four (4) pathways (or LICENSURE METHODS) to Illinois social worker licensure. Use the descriptions below to determine which LICENSURE METHOD best fits your situation. You may apply under only one.

**NON-EXAMINATION – LSW ONLY.** An LSW seeking licensure under Illinois Public Act 102-0326 is not required to complete an examination. This licensure method does not apply to LCSW licensure. **For applications received between July 1, 2023 and June 30, 2024, the fee is waived (no payment required).** Licensure Application Fee \$50.

**ENDORSEMENT** - The applicant in this situation is actively licensed as an LSW or LCSW (or equivalent license) in *another* state or US jurisdiction. This candidate has successfully completed the required licensure examination or may be required to complete it as part of the licensure process. **For applications received between July 1, 2023 and June 30, 2024, the fee is waived (no payment required).** License Application Fee \$200

**ACCEPTANCE OF EXAMINATION - LCSW ONLY.** The applicant in this situation is not actively licensed but has already successfully completed the required licensure examination. **For applications received between July 1, 2023 and June 30, 2024, the fee is waived (no payment required).** After June 30, 2024 the Licensure Application Fee is \$50.

**EXAMINATION (or Pre-Examination Approval) - LCSW ONLY.** The applicant in this situation is not actively licensed and has not successfully completed the required licensure examination. An applicant in this situation is seeking approval from the Illinois Department of Financial and Professional Regulation (Department) and/or the Illinois Social Work Examining and Disciplinary Board (Board) to register and sit for the exam. **For applications received between July 1, 2023 and June 30, 2024, the fee is waived (no payment required).** After June 30, 2024 the Licensure Application Fee is \$50.

For more information about the required licensure examination, please refer to Section 1470.70 of the RULES.

**RESTORATION** - The applicant in this situation already holds an Illinois license as an LSW or LCSW but the license has been inactive or not renewed for five (5) years or more. An application to restore will be reviewed according to the requirements of Rules 68 IAC Section 1470.80 (c). If the license to be restored is INACTIVE, the RESTORATION Application fee is \$60. If the license to be restored is NOT RENEWED, the RESTORATION Application fee is \$200. **(Not eligible for fee waiver.)**

**STEP 3.**

Use the information from STEP 1 and STEP 2 and the chart below to complete **PART I** (Page 1), Box A., Items 1-4 of the application.

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Enter the license desired (from STEP 1).	Enter the corresponding profession code for the license selected in STEP 1.	Select only one licensure method (from STEP 2) that fits your situation and enter it.	Enter the corresponding fee for the licensure method selected in STEP 2.

**STEP 4.**

Complete the rest of the 4-page application, noting the following:

**PART IV: Record of Licensure Information (Page 3)**

Applicants who have never held a social work license may mark N/A for “not available” or “not applicable” in of the application.

**PART V: Record of Examination (Page 3)**

All attempts (pass or fail) of Association of Social Work Boards (ASWB) examinations must be listed. List the level of the exam (ASSOCIATE, BACHELORS, MASTERS, ADVANCED GENERALIST, or CLINICAL). Applicants should also list other state licensing or jurisprudence exams if different than ASWB exams. Candidates who have never taken a licensure examination may mark N/A for “not available” or “not applicable” in of the application.

**PART VII: EXAMINATION CODING INFORMATION**

This portion of the application is not used for LSW or LCSW applications. Please leave this part of the application blank or mark N/A for “not applicable”. A separate examination registration process is followed when an LCSW applicant has been approved to take the exam.

## STEP 5.

**SUPPORTING DOCUMENTS** - The following supporting documents may be required with your application. Read the instructions for each form thoughtfully.

**Licensure Application fee (for your LICENSURE METHOD - please see STEP 2)** - Please make your check or money order payable to IDFPR. **DO NOT SEND CASH.** Pay only one fee for only one licensure method.

**PHQ form** - This form is required to be completed by all applicants.

**ED form(s)** - This form is required for all licensure methods except RESTORATION. The applicant completes the “APPLICANT” portion of the form, then arranges for his or her social work program college or university to complete the “SCHOOL OFFICIAL” portion of the form. The school official’s original signature and seal is required, do not submit photocopies. Do not submit the form unless it has been completed by the social work program. A separate form is required for each college or university through which social work coursework was completed. Education requirements are detailed in RULES Section 1470.30. Candidates with Social Work degrees completed outside of the United States may arrange for their degree to be evaluated by the Council on Social Work Education’s (CSWE) International Social Work Degree Recognition and Evaluation Service.

**CT form** - A candidate who is licensed as a Social Worker in another state or U.S. Jurisdiction must provide Certification of Licensure from his or her first state of social work licensure and the state she or he has most recently been practicing. The applicant must contact the appropriate Board or Agency in the other state(s) to arrange for an original Certification of Licensure to be sent directly to the Department. IDFPR will accept other states' formats for Certification of Licensure in lieu of the CT form as long as the information provided by the other state includes the same basic required information.

**Official Score Report** – A candidate applying under the ENDORSEMENT or ACCEPTANCE OF EXAMINATION licensure methods must contact the Association of Social Worker Boards (ASWB) to arrange for an official, original examination for score report to be sent directly to the Department. [Not applicable to LCSW RESTORATION applicants. A Separate score reporting process is followed for LCSW RESTORATION applicants who are required to retake the exam per Rules 68 IAC Section 1470.80(c).]

**VE-SW** – This form is not required for RESTORATION applications. This form must be completed for all other LCSW applications or for any LSW applicant applying on the basis of a bachelor’s degree and three (3) years’ experience. The applicant completes the “APPLICANT” portion of the form, then arranges for the supervisor to complete the “SUPERVISOR” portion of the form. The Supervisor’s original signature is required - photocopies are not acceptable. Supervised experience requirements are detailed in RULES Section 1470.20. An individual applying under the ENDORSEMENT licensure method who has been licensed at the independent level in another state or U.S. jurisdiction for 5 consecutive years without discipline may submit Certification of Licensure (CT forms) for each state in which the applicant practiced in the last 5 years instead of submitting the following documents: ED form, VE-SW form, Official Score Report.

**Personal History Documents** - An applicant marking “YES” in response to any of the personal history questions in PART VI, page 4 of the application will need to provide a signed, dated personal statement of explanation and corresponding documentation. For criminal issues please provide a certified copy of the disposition from the court or a statement from the court why one is not available. For medical disclosures please provide a physician’s statement that includes whether or not the condition being disclosed will prevent you from performing the essential functions of a social worker.

**Proof of name change(s)** - If any of the supporting documents listed above list a different name than the name on the application, proof of name change(s) must be submitted. An applicant must document each step of each change. Examples of acceptable documentation include: Signed Marriage Certificates, Marriage Licenses, Divorce Decrees, Court orders showing change(s) of name.

**RS form (Restoration Licensure Method only)**

**Continuing Education (Restoration Licensure Method only)** - One seeking to restore a license per Rules 68 IAC Section 1470.80 (c) must submit evidence of completing the Continuing Education requirements (68 IAC Section 1470.95, 68 IAC Section 1130.Subpart E, 20 ILCS 2105/2105-365)

- at least 30 hours;
- not older than 2 years at the time the application is submitted;
- through approved sponsors/providers;
- relevant to the practice of social work;
- could be completed online or in person;
- must include at least 3 hours of ethics;
- must include at least 3 hours pertaining to cultural competence;
- must include at least 1 hour of sexual harassment prevention;
- must include at least 1 hour of implicit bias training;
- must include at least 1 hour in dementia awareness training.

**STEP 6.**

The application, supporting documents, and application fee may be submitted with the application or to:

**Illinois Department of Financial and Professional Regulation  
Division of Professional Regulation  
P.O. Box 7007  
Springfield, Illinois 62791**

An application is valid for 3 years from date it is received by the Department.

Additional application forms can be downloaded from the IDFPR Web site at [www.idfpr.illinois.gov](http://www.idfpr.illinois.gov).

For assistance--Call one of the following numbers and state that you are applying to become licensed as a social worker and need help with your application:

**1-800-560-6420  
TTY - 1-866-325-4949**

Please allow 6 weeks from mailing your application before making an inquiry concerning its status.

# 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.**"

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"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.**"

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# 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. Check the box indicating the appropriate information regarding your application.  Military  Military Spouse  Not Military  Decline to Answer  
 Military service member is defined as: "Service member means any person who, at the time of application under this Section, is an active duty member of the United States Armed Forces or any reserve component of the United States Armed Forces, the Coast Guard, or the National Guard of any state, commonwealth, or territory of the United States or the District of Columbia or whose active duty service concluded within the preceding 2 years before application." The following will be considered proof of you or your spouse's active military status: DD214, Letter of Service signed by Unit Commanding Officer, or Proof of Service document from the Servicemember's electronic personnel portal. Proof for Spouses: Military Permanent Change of Station Orders with the spouse identified by name; Official Notification of Change of Assignment with your marriage license, a certified DD1172 verifying marital status, or a letter signed by the commanding officer verifying change of assignment and the name of the military spouse.

B. 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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C. 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.<br><br><input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying.<br><br><input type="checkbox"/> Other: _____ | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements.<br><br><input type="checkbox"/> 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. SSN OR ITIN _____
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 ____ <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. <b>REQUIRED</b> E-MAIL ADDRESS



**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 (This part must be completed by all applicants)		YES	NO
1. Have you been convicted of or pled guilty or nolo contendere to any criminal offense in any state or in federal court? Please do not give details on minor traffic charges, but do include information relating to Driving While Intoxicated (DWI) charges. <i>If yes, attach a personal statement describing the circumstances of the conviction and certified copies of court records of your conviction including the nature of the offense, date of discharge, and a statement from the probation or parole office. In general, a criminal conviction by itself does not usually result in denial of licensure.</i>			
2. Have you been convicted of a felony? <i>In general, a felony conviction by itself does not usually result in denial of licensure.</i>			
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. Do you now have any disease or condition that presently limits 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? <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 (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


b) CHART III - Select the examination site you desire and enter Test Center Code:

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c) CHART IV - Find your School of Graduation and enter school code:

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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, Tax Information and Workers' Compensation (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.**

Are you more than 30 days delinquent in complying with a child support order? Yes  No

(NOTE: If you are not subject to a child support order, answer "no.")

2. In accordance with 20 ILCS 2105-15(g), "The Department shall deny any license application or renewal authorized under any licensing Act administered by the Department to any person who has failed to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirement of any such tax Act is satisfied."

Are you delinquent in the filing of state taxes? Yes  No

3. In accordance with 20 ILCS 2105/2105-15(g-5), "The Department shall refuse the issuance or renewal of a license to, or suspend or revoke the license of, any individual, corporation, partnership, or other business entity that has been found by the Illinois Workers' Compensation Commission or the Department of Insurance to have failed to secure workers' compensation obligations, or pay in full a fine or penalty imposed due to a failure to secure workers' compensation obligations."

Are you delinquent in complying with workers' compensation obligations? Yes  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. **I UNDERSTAND THAT FEES ARE NOT REFUNDABLE.**

\_\_\_\_\_

Signature of Applicant

\_\_\_\_\_

Date

**IMPORTANT NOTICE:** Completion of this form is necessary to accomplish the requirements outlined in 20 ILCS 2105 of the Civil Administrative Code. Disclosure of this information is REQUIRED.

## HEALTH CARE WORKERS ADDITIONAL PERSONAL HISTORY QUESTIONS

SUPPORTING DOCUMENT

# PHQ

1. NAME      LAST                      FIRST                      MIDDLE

3. PROFESSIONAL LICENSE NUMBER (if any)

\_\_\_\_\_ - \_\_\_\_\_

2. ADDRESS      STREET, CITY, STATE, ZIP CODE

4. SOCIAL SECURITY NUMBER OR ITIN

\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Pursuant to 20 ILCS 2105-165(a), the Department requires the following professionals to disclose information regarding charges or convictions pertaining to certain offenses. **Please check applicable profession.**

- |                                                                                       |                                                                                                               |                                                           |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> Acupuncturist                                                | <input type="checkbox"/> Naprapath                                                                            | <input type="checkbox"/> Psychologist, Clinical (LCP)     |
| <input type="checkbox"/> Advanced Practice Registered Nurse                           | <input type="checkbox"/> Nursing Home Administrator                                                           | <input type="checkbox"/> Podiatrist                       |
| <input type="checkbox"/> Advanced Practice Registered Nurse - Full Practice Authority | <input type="checkbox"/> Occupational Therapist                                                               | <input type="checkbox"/> Prosthetist                      |
| <input type="checkbox"/> Athletic Trainer                                             | <input type="checkbox"/> Occupational Therapy Assistant                                                       | <input type="checkbox"/> Registered Nurse                 |
| <input type="checkbox"/> Audiologist                                                  | <input type="checkbox"/> Optometrist                                                                          | <input type="checkbox"/> Registered Surgical Assistant    |
| <input type="checkbox"/> Behavior Analyst                                             | <input type="checkbox"/> Orthotist                                                                            | <input type="checkbox"/> Registered Surgical Technologist |
| <input type="checkbox"/> Behavior Analyst Assistant                                   | <input type="checkbox"/> Pedorthist                                                                           | <input type="checkbox"/> Respiratory Care Practitioner    |
| <input type="checkbox"/> Certified Midwife                                            | <input type="checkbox"/> Perfusionist                                                                         | <input type="checkbox"/> Sex Offender Associate           |
| <input type="checkbox"/> Chiropractic Physicians (D.C.)                               | <input type="checkbox"/> Pharmacist                                                                           | <input type="checkbox"/> Sex Offender Evaluator           |
| <input type="checkbox"/> Dental Hygienist                                             | <input type="checkbox"/> Physical Therapist                                                                   | <input type="checkbox"/> Sex Offender Treatment Provider  |
| <input type="checkbox"/> Dentist                                                      | <input type="checkbox"/> Physical Therapy Assistant                                                           | <input type="checkbox"/> Social Worker (LSW)              |
| <input type="checkbox"/> Genetic Counselor                                            | <input type="checkbox"/> Physicians, including Medical Doctors (M.D.), Doctors of Osteopathic Medicine (D.O.) | <input type="checkbox"/> Social Worker, Clinical (LCSW)   |
| <input type="checkbox"/> Licensed Practical Nurse                                     | <input type="checkbox"/> Physician Assistant                                                                  | <input type="checkbox"/> Speech Pathologist               |
| <input type="checkbox"/> Marriage and Family Therapist                                | <input type="checkbox"/> Professional Counselor (LPC)                                                         |                                                           |
| <input type="checkbox"/> Marriage and Family Therapist Assoc.                         | <input type="checkbox"/> Professional Counselor, Clinical (LCPC)                                              |                                                           |
| <input type="checkbox"/> Music Therapist                                              |                                                                                                               |                                                           |

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:**

- |                                                                                                                                                                                                                                 | Yes                      | No                       |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1) Are you currently charged with or have you been convicted of a criminal act that requires registration under the Sex Offender Registration Act? *                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Are you currently charged with or have you been convicted of a criminal battery against any patient <i>in the course of patient care or treatment</i> , including any offense based on sexual conduct or sexual penetration? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Are you required, as part of a criminal sentence, to register under the Sex Offender Registration Act? *                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Are you currently charged with or have you been convicted of a forcible felony? *                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |

*If YES to any of the above, attach a personal statement describing the circumstances of the charge or conviction and a certified copy of the court records regarding your charge or conviction, including 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

\_\_\_\_\_  
Email

\_\_\_\_\_  
Date

## \* DEFINITIONS

730 ILCS 150 et. seq.—Acts that require Sex Offender Registration:

(B) As used in this Article, "sex offense" means:

(1) A violation of any of the following Sections of the Criminal Code of 1961:

- 11-20.1 (child pornography),
- 11-20.3 (aggravated child pornography),
- 11-6 (indecent solicitation of a child),
- 11-9.1 (sexual exploitation of a child),
- 11-9.2 (custodial sexual misconduct),
- 11-9.5 (sexual misconduct with a person with a disability),
- 11-15.1 (soliciting for a juvenile prostitute),
- 11-18.1 (patronizing a juvenile prostitute),
- 11-17.1 (keeping a place of juvenile prostitution),
- 11-19.1 (juvenile pimping),
- 11-19.2 (exploitation of a child),
- 11-25 (grooming),
- 11-26 (traveling to meet a minor),
- 12-13 (criminal sexual assault),
- 12-14 (aggravated criminal sexual assault),
- 12-14.1 (predatory criminal sexual assault of a child),
- 12-15 (criminal sexual abuse),
- 12-16 (aggravated criminal sexual abuse),
- 12-33 (ritualized abuse of a child).

An attempt to commit any of these offenses.

(1.5) A violation of any of the following Sections of the Criminal Code of 1961, when the victim is a person under 18 years of age, the defendant is not a parent of the victim, the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act, and the offense was committed on or after January 1, 1996:

- 10-1 (kidnapping),
- 10-2 (aggravated kidnapping),
- 10-3 (unlawful restraint),
- 10-3.1 (aggravated unlawful restraint).

(1.6) First degree murder under Section 9-1 of the Criminal Code of 1961, when the victim was a person under 18 years of age and the defendant was at least 17 years of age at the time of the commission of the offense, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.7) (Blank).

(1.8) A violation or attempted violation of Section 11-11 (sexual relations within families) of the Criminal Code of 1961, and the offense was committed on or after June 1, 1997.

(1.9) Child abduction under paragraph (10) of subsection (b) of Section 105 of the Criminal Code of 1961 committed by luring or attempting to lure a child under the age of 16 into a motor vehicle, building, house trailer, or dwelling place without the consent of the parent or lawful custodian of the child for other than a lawful purpose and the offense was committed on or after January 1, 1998, provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act.

(1.10) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after July 1, 1999:

- 10-4 (forcible detention, if the victim is under 18 years of age), provided the offense was sexually motivated as defined in Section 10 of the Sex Offender Management Board Act,
- 11-6.5 (indecent solicitation of an adult),
- 11-15 (soliciting for a prostitute, if the victim is under 18 years of age),
- 11-16 (pandering, if the victim is under 18 years of age),
- 11-18 (patronizing a prostitute, if the victim is under 18 years of age),
- 11-19 (pimping, if the victim is under 18 years of age).

(1.11) A violation or attempted violation of any of the following Sections of the Criminal Code of 1961 when the offense was committed on or after August 22, 2002:

- 11-9 (public indecency for a third or subsequent conviction).

(1.12) A violation or attempted violation of Section 5.1 of the Wrongs to Children Act (permitting sexual abuse) when the offense was committed on or after August 22, 2002.

(2) A violation of any former law of this State substantially equivalent to any offense listed in subsection (B) of this Section.

(C) A conviction for an offense of federal law, Uniform Code of Military Justice, or the law of another state or a foreign country that is substantially equivalent to any offense listed in subsections (B), (C), (E), and (E5) of this Section shall constitute a conviction for the purpose of this Article.

## \* DEFINITIONS

A “**forcible felony**”, for the purposes of Section 2105-165 of the Code (section numbers are from the Criminal Code of 1961 [720 ILCS 5]) and 68 Illinois Administrative Code 1130.120 is one or more of the following offenses:

- a) First Degree Murder (Section 9-1);
- b) Intentional Homicide of an Unborn Child (Section 9-1.2);
- c) Second Degree Murder (Section 9-2);
- d) Voluntary Manslaughter of an Unborn Child (Section 9-2.1);
- e) Drug-induced Homicide (Section 9-3.3);
- f) Kidnapping (Section 10-1);
- g) Aggravated Kidnapping (Section 10-2);
- h) Unlawful Restraint (Section 10-3);
- i) Aggravated Unlawful Restraint (Section 10-3.1);
- j) Forcible Detention (Section 10-4);
- k) Involuntary Servitude (Section 10-9(b));
- l) Involuntary Sexual Servitude of a Minor (Section 10-9(c));
- m) Trafficking in Persons (Section 10-9(d));
- n) Criminal Sexual Assault (Section 11-1.20);
- o) Aggravated Criminal Sexual Assault (Section 11-1.30);
- p) Predatory Criminal Sexual Assault of a Child (Section 11-1.40);
- q) Criminal Sexual Abuse (Section 11-1.50);
- r) Aggravated Criminal Sexual Abuse (Section 11-1.60);
- s) Aggravated Battery (Section 12-3.05);
- t) Compelling Organization Membership of Persons (Section 12-6.5);
- u) Compelling Confession or Information by Force or Threat (Section 12-7);
- v) Home Invasion (Section 12-11);
- w) Robbery (Section 18-1);
- x) Armed Robbery (Section 18-2);
- y) Vehicular Hijacking (Section 18-3);
- z) Aggravated Vehicular Hijacking (Section 18-4);
- aa) Aggravated Robbery (Section 18-5);
- bb) Terrorism (Section 29D-14.9);
- cc) Causing a Catastrophe (Section 29D-15.1);
- dd) Possession of a Deadly Substance (Section 29D-15.2);
- ee) Making a Terrorist Threat (Section 29D-20);
- ff) Falsely Making a Terrorist Threat (Section 29D-25);
- gg) Material Support for Terrorism (Section 29D-29.9);
- hh) Hindering Prosecution of Terrorism (Section 29D-35);
- ii) Boarding or Attempting to Board an Aircraft with Weapon (Section 29D-35.1);
- jj) Armed Violence (Section 33A-2); and
- kk) Attempt (Section 8-4) of any of the above specified offenses.

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**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.

**CERTIFICATION BY LICENSING AGENCY / BOARD**

SUPPORTING DOCUMENT

**CT**

**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	2. DATE OF BIRTH ____ / ____ / ____ Month Day Year	3. SSN OR ITIN - - - - -
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.  _____ Profession Name Profession Code	
6. MAIDEN OR GIVEN SURNAME	7. APPLICANT TELEPHONE NUMBER (Daytime) Area Code ( ____ ) _____ - _____	
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 \_\_\_\_\_ to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service, the information requested below.  
Name of Licensing Agency or Board

Signature \_\_\_\_\_ Date \_\_\_\_\_

**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	
<input type="checkbox"/> Examination (Administered in Your State)	<input type="checkbox"/> Reciprocity with (State) _____
<input type="checkbox"/> National (Name) _____	<input type="checkbox"/> Waiver/Grandfather
<input type="checkbox"/> State Constructed _____	<input type="checkbox"/> Credentials
<input type="checkbox"/> Other (Name) _____	<input type="checkbox"/> Other (Describe) _____
<input type="checkbox"/> Endorsement of License (State)	
Acceptance of Examination Results _____	
(Administered in Another State)	

F. CURRENT LICENSURE STATUS	G. IF LICENSED BY EXAMINATION, RECORD SCORES
<input type="checkbox"/> Active	Type of Examination _____ Score _____
<input type="checkbox"/> Inactive	Written _____
<input type="checkbox"/> Lapsed	Practical _____
<input type="checkbox"/> Other (Explain) _____	Other (Describe) _____
_____	Received no Grade Below _____
_____	Examination Period ____ days ____ hours

**PART III - CERTIFICATION OF EXAMINATION SCORES**

A1. National or other Profession Specific Examination  
(Record all available information)

Date of Examination \_\_\_\_\_

Scaled Score	_____	Raw Score	_____
Standard Deviation	_____	Corrected Score	_____
National Mean	_____	Percent Score	_____

A 2

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

B. State Constructed Examination

SUBJECT	DATE	SCORE	SUBJECT	DATE	SCORE

**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.

SEAL

\_\_\_\_\_

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.**



NAME (Last, First, MI):

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

Large empty rectangular box for recording additional information.

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

\_\_\_\_\_
Print Name of School Official

\_\_\_\_\_
Signature of School Official

\_\_\_\_\_
Title

\_\_\_\_\_
Date

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\_\_.

\_\_\_\_\_
Date of Expiration

\_\_\_\_\_
Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

SSN OR ITIN:

Profession:

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 20/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**SOCIAL WORK  
VERIFICATION OF  
SUPERVISION & EXPERIENCE**

SUPPORTING DOCUMENT

**VE-SW**

**APPLICANT: Complete the applicant section of this form, then forward it to your supervisor(s). A separate form is required from each supervisor for each experience.**

1. NAME LAST                      FIRST                      MIDDLE	2. DATE OF BIRTH ____ / ____ / ____ Month    Day    Year	3. SSN OR ITIN ____ - ____ - ____
------------------------------------------------------------------------	----------------------------------------------------------------	--------------------------------------

4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. PROFESSION (Check One)  <input type="checkbox"/> <b>Licensed Social Worker (150)</b> <input type="checkbox"/> <b>Licensed Clinical Social Worker (149)</b>
6. MAIDEN OR GIVEN SURNAME	

COMPLETE BOXES 7, 8, 9, 10 AND 11 TO REFLECT INFORMATION AT TIME OF EMPLOYMENT/EXPERIENCE

7. CLINICAL SUPERVISOR'S NAME & TITLE	11. TYPE OF EXPERIENCE BEING REPORTED (MARK ONLY ONE- A SEPARATE FORM IS REQUIRED FOR EACH EXPERIENCE).  <input type="checkbox"/> <b>Bachelor's degree + 3 years experience for LSW</b> Rules 68 IAC Section 1470.20(b)  <input type="checkbox"/> <b>3000 Supervised Clinical Hours for LCSW</b> Rules 68 IAC Section 1470.20(a)  <input type="checkbox"/> <b>Exam Alternative for LCSW</b> 225 ILCS 20/8.2
8. BUSINESS / INSTITUTION / SITE OF EXPERIENCE HOURS	
9. BUSINESS / INSTITUTION / SITE ADDRESS	
10. SUPERVISION WAS (Mark only one):  <input type="checkbox"/> <b>Internal</b> OR <input type="checkbox"/> <b>Contracted Outside Supervision</b>	

**SUPERVISOR: Complete the remainder of this form. RETURN THE COMPLETED FORM DIRECTLY TO THE APPLICANT IN A SEALED ENVELOPE.**

**PART I. - SOCIAL WORK SUPERVISION INFORMATION**

A. NAME OF SUPERVISOR COMPLETING THIS FORM	H. The individual listed above and I met for an average of at least 4 hours each month for the purpose of conducting supervision. <input type="checkbox"/> YES <input type="checkbox"/> NO  If NO, how often was supervision? _____ hours / month.
B. QUALIFICATION TO SUPERVISE:  <input type="checkbox"/> Licensed Clinical Social Worker (LCSW) <input type="checkbox"/> Licensed Social Worker (LSW) For LSW licensure only <input type="checkbox"/> Licensed Clinical Professional Counselor (LCPC) <input type="checkbox"/> Licensed Marriage and Family Therapist (LMFT) <input type="checkbox"/> Licensed Clinical Psychologist <input type="checkbox"/> Licensed Psychiatrist <input type="checkbox"/> Licensed Advanced Practice Psychiatric Nurse <input type="checkbox"/> Other (specify): _____	I. My supervision was coordinated with another clinical supervisor. <input type="checkbox"/> YES <input type="checkbox"/> NO  If YES, the other supervisor's name was:  _____
C. LICENSE STATE    D. LICENSE NUMBER    E. DATE AWARDED	J. APPLICANT'S JOB TITLE AT TIME EXPERIENCE
F. BUSINESS TELEPHONE NUMBER  Area Code ( ____ )    _____	K. NAME OF SUPERVISOR'S BUSINESS / INSTITUTION / AGENCY
G. EMAIL ADDRESS (OF SUPERVISOR COMPLETING THIS FORM)	L. SUPERVISOR'S BUSINESS/ INSTITUTION/ AGENCY ADDRESS

**PART I. - SOCIAL WORK SUPERVISION INFORMATION (Continued)**

**NAME (Last, First, MI):**

**M. Bachelor's + 3 years experience for LSW.** THIS BOX IS ONLY FOR HOURS COMPLETED FOR FIRST TIME ILLINOIS LSW LICENSURE ON THE BASIS OF A BACHELOR'S DEGREE PURSUANT TO RULES 68 IAC SECTION 1470.20(b).

The applicant completed the following supervised **PROFESSIONAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

\_\_\_\_\_ (must be **after** Bachelor's degree was awarded) \_\_\_\_\_ Total: \_\_\_\_\_  
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY) MONTHS and YEARS

The experience was conducted in accordance with Rules 68 IAC Section 1470.20(b).  YES  NO

**N. 3000 Supervised Clinical Hours for LCSW (2000 for Doctorate degree applicants).** THIS BOX IS ONLY FOR HOURS COMPLETED FOR FIRST TIME IL LCSW LICENSURE PURSUANT TO RULES 68 IAC SECTION 1470.20(a).

The applicant completed the following supervised **CLINICAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

\_\_\_\_\_ (must be **after** Master's or Doctorate degree was awarded) \_\_\_\_\_  
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY)

The experience is ongoing.  YES  NO Total Number Clinical Hours: \_\_\_\_\_

The experience was conducted in accordance with Rules 68 IAC Section 1470.20(a).  YES  NO

**O. Exam Alternative for LCSW.** THIS BOX IS ONLY FOR HOURS COMPLETED FOR LCSW EXAM ALTERNATIVE PURSUANT TO 225 ILCS 20/8.2.

The applicant completed the following supervised **PROFESSIONAL** experience under my supervision. The experience being counted and reported started as listed below and continued at least until the end date listed below.

\_\_\_\_\_ (must be **after** clinical experience of 1470.20(a).) \_\_\_\_\_ Total hours: \_\_\_\_\_  
START DATE (MM/DD/YYYY) END DATE (MM/DD/YYYY) (EXAM ALTERNATIVE HOURS ONLY)

The experience I am verifying was separate from (and in addition to) the 3000 hours (2000 for doctorate degree applicants) completed or counted for supervised clinical experience per Rules 68 IAC Section 1470.20(a).

YES  NO

The experience was conducted in accordance with 225 ILCS 20/8.2.  YES  NO

P. The applicant's performance was satisfactory or better.  YES  NO

The above indicated experience has been documented by myself and has been performed by the applicant pursuant to my order, control, and full professional and legal responsibility as a supervisor. I do hereby declare that the information contained herein is true and correct.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**SSN OR ITIN:**

**Profession:**