

CLINICAL PSYCHOLOGIST TEMPORARY AUTHORIZATION

This form may be completed in conjunction with a request for temporary authorization to practice pursuant to Section 11.5 of the Illinois Clinical Psychologist Licensing Act (225 ILCS 15/11.5)

Last Name	First Name	Middle Initial	Degree	SSN OR ITIN _ _ _ - _ _ - _ _ _	Date Of Birth _ _ / _ _ / _ _ Month Day Year
Mailing Address: Number and Street				Email address	
City				State	Zip Code

AFFIDAVIT

I, _____, under oath do solemnly swear under penalties of perjury that the following statements, to the best of my knowledge, are true, correct and complete:

- 1) THAT I am licensed in good standing to practice psychology independently and at the Doctorate level in the State of _____;
- 2) THAT my license number _____ has not been encumbered or disciplined in any way by any licensing authority;
- 3) THAT to the best of my knowledge, there are no pending investigations or outstanding complaints against me or my license;
- 4) THAT I have arranged for Certification of my home state Psychologist License to be provided to the Illinois Department of Financial and Professional Regulation;
- 5) THAT the above stated information is truthful.

SUBSCRIBED & SWORN

before me this _____
day of _____, 20____.

FURTHER, Affiant sayeth not.

Name

NOTARY PUBLIC

Return completed, notarized affidavit to:

**Certification of Licensure
is required.**

Illinois Department of Financial and Professional Regulation
Health Services Section
320 W. Washington St.
Springfield, IL 62786