

# INSTRUCTION SHEET

## Surgical Assistant

### Acceptance of Examination Endorsement

***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.***

To apply for licensure as a surgical assistant in Illinois, read and then follow the directions as they apply to you. This will aid you in accurately completing your application and thus, eliminate any delay in processing. **The application which you submit is valid for 3 years from date of receipt.** Applicants must be at least 21 years of age. All Illinois Surgical Assistant licenses expire April 30 of each even-numbered year.

All applicants must complete the 4-page application and submit it with the supporting documents required by the method under which application is being made. You may apply for licensure by acceptance of examination or endorsement.

#### 4-page Application

Complete the four-page Application for Licensure/Examination as follows:

1. Part I-A, Application Category Information--Select method of application and complete Part I as indicated below:

1. Profession Name	2. Profession Code	3. Licensure Method	4. Fee
Surgical Assistant	238	Acceptance of Examination	\$100.00
Surgical Assistant	238	Endorsement	\$100.00

2. Part I-B, Check the box indicating the appropriate information regarding your application.
3. Part II, Applicant Identifying Information--Enter all applicable information requested. You must include your social security number in box 3.
4. Part III, Education Information
  - a. Numbers 1 through 5--Enter all applicable information requested.
  - b. Number 6--Indicate all post secondary education which you have attended since graduation from high school. Please indicate beginning and ending dates by month and year.
5. Part IV, Record of Licensure Information--Indicate in this area whether or not you have ever held a license as a Surgical Assistant or a related license. Supporting document CT must also be completed by all states in which you are/were licensed.
6. Part V, Record of Examination--Enter all applicable information requested.
7. Part VI, Personal History Instructions--Must be completed by all applicants.

*Send Application and  
Supporting Documents to:*

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

*Fee--Payment must be in the  
form of a check or money order  
made payable to:*

**Department of Financial and  
Professional Regulation**

**FEE IS NOT  
REFUNDABLE.**

#### **For Assistance Call:**

*Department of Financial and  
Professional Regulation at:*  
**800-560-6420**

*Telecommunicative Device for  
the Deaf at:* **217-524-6735**

*Please allow 45 days from  
mailing your application before  
making an inquiry concerning its  
status.*

**4-Page Application  
(cont'd)**

8. Part VII, Examination Coding Information--Not Applicable.
9. Part VIII, Child Support and Student Loan Information--Must be completed by all applicants.
10. Part IX, Certifying Statement--Read the certifying statement and then sign and date your application.

	<b>Acceptance of Examination</b>	
--	----------------------------------	--

***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.***

*No Reference Sheet is included with this packet. When supporting documents request you refer to the Reference Sheet, enter the information recorded in Part I-A of the four-page Application for Licensure/Examination onto the supporting document.*

If you wish to apply for licensure on the basis of Acceptance of Examination, the following supporting documents must be submitted with the 4-page application and required fee.

1. Supporting Document PHQ **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. **Current certification by one of the following certifying bodies:**
  - a. the National Commission for the Certification of Surgical Assistants as a Certified Surgical Assistant;
  - b. the National Board of Surgical Technology and Surgical Assisting as a Certified Surgical First Assistant; or
  - c. American Board of Surgical Assistants as Surgical Assistant-Certified.

**A Supporting Document Affidavit (AFF-SA) certifying active membership in one of the surgical assistant organizations listed above must be submitted by the appropriate organization.**

3. **CT (Certification of Licensure)**--Supporting Document **CT** must be completed by the jurisdiction in which you were originally licensed as a surgical assistant and from the jurisdiction of **current** licensure. You must direct the licensing agency/board to return completed form **CT** directly to you. You may copy this form if necessary.

---

---

	<b>Endorsement</b>	
--	--------------------	--

***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.***

*No Reference Sheet is included with this packet. When supporting documents request you refer to the Reference Sheet, enter the information recorded in Part I-A of the four-page Application for Licensure/Examination onto the supporting document.*

If you wish to apply for licensure on the basis of Endorsement, the following supporting documents must be submitted with the 4-page application and required fee.

1. Supporting Document PHQ **must** be completed and submitted with each application. Your application will not be processed without completion of this form.
2. **Current certification by one of the following certifying bodies:**
  - a. the National Commission for the Certification of Surgical Assistants as a Certified Surgical Assistant;
  - b. the National Board of Surgical Technology and Surgical Assisting as a Certified Surgical First Assistant; or
  - c. American Board of Surgical Assistants as Surgical Assistant-Certified.

**A Supporting Document Affidavit (AFF-SA) certifying active membership in one of the surgical assistant organizations listed above must be submitted by the appropriate organization.**

3. **CT (Certification of Licensure)**--Supporting document CT must be completed by the jurisdiction in which you were originally licensed as a surgical assistant and from the jurisdiction of **current** licensure. You must direct the licensing agency/board to return completed form CT directly to you.

## LICENSURE METHODS AND DEFINITIONS

*Following are definitions of the various methods used in issuing licenses for professionals in the State of Illinois. Some of these licensure methods may not be applicable to your profession. Refer to the enclosed instruction sheet to determine the specific licensure methods/requirements for your profession.*

### Licensure Methods

### Definition

#### Examination

Applicant has applied or is required to take and pass all or a portion of an exam scheduled and/or given by the Department or a representative of the Department.

#### Endorsement of License

Original license issued in another state and that state's requirements were substantially equivalent to Illinois requirements at time license was issued.

#### Acceptance of Examination

Applicant has taken a National Exam, referred to by Illinois statute, in any state. Applicant may or may not be licensed in another state.

#### Restoration

Applicant has previously been licensed in State of Illinois and has allowed license to lapse long enough to require reapplication. Possible exam passage and/or committee review.

#### Grandfather/Waiver

Applicant will be licensed without regard to current requirements because statute allows this based on past qualification and practices (for a specified time only).

#### Non-examination

Applicant is licensed by meeting qualifications required by statute. There is no exam for these professions. These can be either businesses or individuals.

# 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.**"

---

"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.**"

# Illinois Department of Financial and Professional Regulation

## Division of Professional Regulation

### Application Checklist for Surgical Assistant

*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!

FOUR-PAGE APPLICATION REVIEW		COMPLETED
Part I.	Application Category Information	
Part II.	Applicant Identifying Information	
Part III.	Education Information	
Part IV.	Record of Licensure Information	
Part V.	Record of Examination	
Part VI.	Personal History Information	
Part VII.	Examination Coding Information (if applicable)	
Part VIII.	Child Support and/or Student Loan Information	
Part IX.	Certifying Statement--Signed and Dated	
SUPPORTING DOCUMENTS		SUBMITTED
Application Fee		
Supporting Document CCA <b><u>must</u></b> be completed and submitted with each application. Your application will not be processed without completion of this form.		
CT (Certificate of Licensure) Form from the jurisdiction of original and current licensure		
AFF-SA Form		

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. 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 \$
--------------------	----------------------------	---------------------	--------------

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.   | <input type="checkbox"/> My application for this profession had previously been denied in Illinois. I am reapplying since I have fulfilled additional requirements. |
| <input type="checkbox"/> I have previously made application for this profession in Illinois. However, my previous application expired and I am now reapplying. | <input type="checkbox"/> I have previously made application for this profession in Illinois. However, I am now applying under new statutory language.               |
| <input type="checkbox"/> 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		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 ____ <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	

NAME (Last, First, MI):

SS#:

Profession:

**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 ☐ No2. NAME OF LAST PRELIMINARY SCHOOL  
ATTENDED3. 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 ☐ No6. COLLEGE OR UNIVERSITY NAME  
(Undergraduate and Graduate)LOCATION  
(City and State or Country)

DATES OF ATTENDANCE

FROM

TO

TYPE OF  
DEGREE EARNED

Month/Year

Month/Year

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?

Month/Year

Month/Year

☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No☐ Yes ☐ No



**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.)*

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

**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"/> Podiatrist   | <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.

**This page intentionally left blank  
for double-sided printing.**

**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. SOCIAL SECURITY NUMBER ____ - ____ - ____
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  
Name of Licensing Agency or Board  
Financial and Professional Regulation or its designated testing service, the information requested below.

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"/> National (Name) _____ <input type="checkbox"/> State Constructed _____ <input type="checkbox"/> Other (Name) _____ <input type="checkbox"/> Endorsement of License (State) Acceptance of Examination Results _____ (Administered in Another State) <input type="checkbox"/> Reciprocity with (State) _____ <input type="checkbox"/> Waiver/Grandfather _____ <input type="checkbox"/> Credentials _____ <input type="checkbox"/> Other (Describe) _____	
F. CURRENT LICENSURE STATUS <input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Lapsed <input type="checkbox"/> Other (Explain) _____ _____ _____	G. IF LICENSED BY EXAMINATION, RECORD SCORES Type of Examination Score Written _____ Practical _____ 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.**



IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 57/1 et.seq (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

**AFFIDAVIT**  
**Certification of Membership in a**  
**Surgical Assistant Organization**

SUPPORTING DOCUMENT

**AFF-SA**

**APPLICANT:** *Complete the application section of this form. Forward the form to the appropriate surgical assistant organization who will attest to personal knowledge of your membership. The completed form must be returned directly to the Department of Financial and Professional Regulation, Attn: Division of Professional Regulation.*

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		

**Professional Organization:** *Complete the remainder of this form and return directly to the applicant at the above address in a sealed envelope.*

A. NAME OF PROFESSIONAL SURGICAL ASSISTANT ORGANIZATION	B. BUSINESS TELEPHONE Area Code (____) ____ - ____
C. ADDRESS STREET, CITY, STATE, ZIP CODE	D. NAME OF NATIONAL CERTIFYING EXAMINATION AND DATE OF SUCCESSFUL COMPLETION: ____ / ____ / ____ Month Day Year
E. SUCCESSFUL COMPLETION OF A PROGRAM OF SURGICAL ASSISTING APPROVED BY THE COMMISSION ON ACCREDITATION OF ALLIED HEALTH EDUCATION PROGRAMS OR A UNITED STATES MILITARY PROGRAM THAT EMPHASIZED SURGICAL ASSISTING:  Name of Program: _____  Date of Graduation: _____	F. IF THE INDIVIDUAL IS A FOREIGN MEDICAL SCHOOL GRADUATE, THE FOLLOWING HAS BEEN VERIFIED ( <i>CHECK ALL REQUIREMENTS THAT HAVE BEEN VERIFIED FOR CERTIFICATION BY YOUR ORGANIZATION</i> ):  <input type="checkbox"/> Copy of medical school diploma or reference letter verifying surgical training and experience from the medical school;  <input type="checkbox"/> Reference letter from a U.S. sponsoring surgeon who has evaluated the individual's skills.

I hereby attest that the information provided herein is true and correct to the best of my knowledge.

SEAL

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name Affiant

\_\_\_\_\_  
Date