# (125) Temporary Physician Initial Licensure Checklist

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# General Information

## Instructions:

### *Temporary Physician License*

1. Before completing your online application, please read each step below. This will aid you in accurately completing your application and eliminate delays in processing. The application requirements listed below follow the same order as the online application questions.

2. Applications must be submitted to the IDFPR at least 60 days prior to the applicant's scheduled start date in the postgraduate clinical training program.

3. Disclosure of your U.S. Social Security Number (SSN), if you have one, is mandatory, in accordance with 5 ILCS 100/10-65 to obtain a license. The 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.

4. Any document in a foreign language must be accompanied by an original, notarized translation that has been transcribed by a person other than the applicant, who is fluent in both English and the language of the document. The translator must certify to the above requirements as well as to the accuracy of the translation.

5. The application fee for an initial license is $230.00 and is non-refundable.

6. Applicants may monitor the status of their license application through the IDFPR Online Services Portal. In addition, each GME office has a separate account through the online portal where the hospital may access and monitor the status of temporary license applications submitted by their residents.

7. After the license application is complete, the temporary license shall be issued to the hospital sponsoring the postgraduate clinical training program. The applicant shall not commence training until the temporary license has been issued by the IDFPR designating the effective date and expiration date of the license.

# Qualifications:

## *Temporary Physician License*

1. Applicant must have been accepted for specialty training in a program of postgraduate clinical training approved by the IDFPR. The initial temporary license shall be issued for 1, 2, or 3 years based on the program's accredited length of training as determined by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

2. Applicant must have completed at least two (2) academic years of instruction in a college, university, or other institution. An academic year is a minimum period of nine (9) months.

3. Applicant must have graduated from a medical college or an osteopathic medical college:

(A) Located in the United States or Canada accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA); or

(B) Located outside of the United States or Canada that meets the following requirements:

(1) The medical college is officially recognized by the jurisdiction in which it is located for the purpose of receiving a license to practice medicine in all of its branches.

(2) The medical program consists of at least two (2) academic years of study in the basic medical sciences; and at least two (2) academic years of study in the clinical sciences. An academic year is a minimum period of nine (9) months.

(3) The clinical sciences must have been completed while enrolled in the medical college which conferred the degree. This must include at least four (4) weeks of core clerkship rotations in internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and surgery. The core clerkship rotations must have been taken and completed in clinical teaching facilities owned, operated or formally affiliated with the medical college which conferred the degree or under contract in teaching facilities owned, operated or affiliated with another medical college which is officially recognized by the jurisdiction in which the medical school which conferred the degree is located.

4. Applicant who is a graduate of a medical college located outside of the United States or Canada must be hold a current and valid certification issued by the Educational Commission for Foreign Medical Graduates (ECFMG).

5. Applicant must have been engaged in the active practice of medicine or engaged in formal study or training in a program of medicine in the five (5) years preceding the date of application. Otherwise, applicant must demonstrate proof of professional capacity, i.e. 150 CME hours AMA PRA Category 1 Credit.

6. Applicant who has been granted a license to practice medicine in another jurisdiction must demonstrate official proof of original licensure and current licensure held.

7. Applicant must be of good moral character, i.e. no conduct/activities that would constitute grounds for discipline under the Medical Practice Act.

# Application Requirements

| Licensure Method | Requirements | Submitted: |
|---|---|---|
| **Temporary Physician Initial Licensure Nonexamination** | 1. Completed online application including all required information:<br>• Public and Mailing Address<br>• Place of Birth<br>• Date of Birth<br>• Name Change<br>• Education Location<br>• Education Information<br>• Postgraduate Clinical Training Information<br>• Record of Licensure<br><br>2. Applicant must upload official transcript verifying completion of at least two (2) academic years of instruction in a college, university, or other institution. Transcript must bear official seal and signature of the institution. Note: Graduates from a 6-year medical program, please proceed to next question to upload official transcript verifying 6-year medical program.<br><br>3. Applicant must upload official medical college transcript including degree conferred and graduation date. If transcript does not include degree conferred and graduation date, applicant must upload copy of medical diploma.<br><br>*For current year U.S. graduates, applicant must upload both an official transcript AND a certification of graduation (Supporting Document ED-MED) issued by the medical college. Both the medical transcript and ED-MED must be issued not more than 30 days prior to applicant's expected graduation date. Incomplete forms will not be accepted. ED-MED form is included at the end of the checklist. | ONLINE PORTAL |

| | | |
|---|---|---|
| | 4. Applicant who is a graduate of a medical college located outside of the United States or Canada must upload Supporting Document ED-NON completed by the applicant's medical college. The document must verify that the applicant has met the requirements found under Qualifications (3)(B)(1-3) detailed above. The document must be currently dated and signed by the Dean of the medical college and bear the official seal of the medical college. Incomplete forms will not be accepted. ED-NON form is included at the end of the checklist.<br><br>5. Applicant must upload Supporting Document CA-MED completed by the Program Director of a postgraduate clinical training program approved by the IDFPR. The document must be currently dated and signed by the Program Director and bear the official seal of the hospital sponsoring the training program. Incomplete forms will not be accepted. CA-MED form is included at the end of the checklist.<br><br>6. Applicant who is a graduate of a medical college located outside of the United States or Canada must upload proof of satisfactory completion of an internship or social service if it was required for the conferral of the applicant's medical degree.<br><br>7. Applicant who is a graduate of a medical college located outside of the United States or Canada must upload proof of current and valid certification issued by the ECFMG.<br><br>8. Applicant must verify work history related to the practice of medicine in the five (5) years preceding the date of application. This information may be necessary to demonstrate the applicant's professional capacity. If the applicant has not been engaged in formal study or training in a program of medicine or engaged in the active practice of medicine in the five (5) years preceding the date of application, applicant must upload proof of professional capacity, i.e. documentation verifying completion of 150 CME hours of AMA PRA Category 1 Credit. | |

| | | |
|---|---|---|
| | 9. Applicant who has been granted a license to practice medicine in another U.S. state or in a foreign country must submit official license certifications from the jurisdiction of original licensure and the jurisdiction of current licensure.<br><br>10. Applicant must answer questions about:<br>• Health care worker licensure pursuant to 20 ILCS 2105-165(a)<br>• Discipline or action taken by hospitals or other health care entities, insurance carriers, or professional societies or associations<br>• Criminal convictions, discharge from military service or government position, disease or condition that interferes with professional work<br>• Child support, student loan, and tax compliance | |

# Application Fees

| ***Fees collected through the licensing process are NOT REFUNDABLE OR TRANSFERABLE.*** | | |
|---|---|---|
| **Complete** | **License Type** | **Submitted:** |
| 1. | (125) Temporary Physician License ..... $230.00 | ONLINE PORTAL |
| ***NOTES: All major credit and debit cards as well as ACH and eCheck are accepted.*** | | |

**IMPORTANT NOTICE**: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFICATE OF ACCEPTANCE FOR SPECIALTY/RESIDENCY PROGRAM

SUPPORTING DOCUMENT

# CA-MED

**NOTE: An applicant shall not commence specialty/residency training before the sponsoring institution receives notice from the Department of Financial and Professional Regulation that the required licensure has been approved.**

**APPLICANT: Complete the applicant section of this form, then forward it to the institution sponsoring your internship, residency, or clinical fellowship for completion of the remainder of the form.**

| 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. | |
| 6. *MAIDEN OR GIVEN SURNAME* | _____ Profession Name | __ __ __ Profession Code |

**ADMINISTRATOR: Complete the remainder of this form and return it to the applicant.**

| A. *NAME OF SPONSORING INSTITUTION* | B. *START DATE* __ __ / __ __ / __ __ __ __ Month Day Year | C. *COMPLETION DATE* __ __ / __ __ / __ __ __ __ Month Day Year |
|---|---|---|
| D. *PROGRAM SITE (STREET ADDRESS, CITY, STATE, ZIP CODE)* | E. *SPECIALTY NAME AND PROGRAM LENGTH* | |
| F. BUSINESS TELEPHONE NUMBER Area Code ( __ __ __ ) __ __ __ — __ __ __ __ | G. *POST-GRADUATE YEAR (PGY) FOR DATES LISTED ABOVE, e.g., 1-3, 4, etc.)* | |

I do hereby declare that the above named applicant will be accepted for specialty/residency training as indicated above if, subsequent to the evaluation of medical education and/or clinical skills by the Department of Financial and Professional Regulation, the applicant is found to be eligible for licensure.

_____
Signature of Program Director

_____
Print Name of Program Director

*SEAL*

_____
Title

_____
Date

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et.seq. Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFICATION OF GRADUATION

**(Current Year Graduates of LCME and COCA-Accredited Programs Only)**

SUPPORTING DOCUMENT

# ED - MED

**APPLICANT:** ***Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.***

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH

__ __ / __ __ / __ __ __ __
Month Day Year

3. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

6. MAIDEN OR GIVEN SURNAME

_____ ___ ___ ___
Profession Name Profession Code

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

_____ _____
Date Signature

**SCHOOL OFFICIAL:** Complete the bottom portion of this page and return **ALONG** with a current official medical school transcript. **DO NOT** certify this form more than **45 days** prior to the graduation date.

A. MEDICAL SCHOOL INFORMATION

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

B. DATES OF ATTENDANCE

Start: __ __ / __ __ / __ __ __ __
Month Day Year

End: __ __ / __ __ / __ __ __ __
Month Day Year

Degree: _____ MD _____ DO

C.

Applicant will complete all requirements for the medical degree as of __ __ / __ __ / __ __ __ __ and will graduate on __ __ / __ __ / __ __ __ __ .
Month Day Year Month Day Year

***When this form is certified prior to the actual graduation of the applicant, the school official is responsible for notifying the Department of Financial and Professional Regulation of any failure on the part of the applicant to complete the requirements for graduation.***

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

_____
Signature of School Official

SCHOOL

S E A L

_____
Print Name of School Official

_____
Title

_____
Date

**IMPORTANT NOTICE**: Completion of this form is necessary for consideration for licensure under 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# CERTIFICATION OF EDUCATION NON-LCME ACCREDITED MEDICAL COLLEGE

SUPPORTING DOCUMENT

# ED- NON

**APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form. You are authorized to photocopy this form as necessary.**

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month / Day / Year)

3. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

☐ Permanent Physician 036

☐ Temporary Physician 125

4. SOCIAL SECURITY NUMBER __ __ __-__ __-__ __ __ __ OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER __ __ __ __ __ __ __ __ __

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date _____ Signature of Applicant _____

**APPLICANT: DO NOT COMPLETE ANY PORTION BELOW THE LINE.**

**DEAN OF MEDICAL SCHOOL: Complete the bottom portion of this page and the reverse side, then return to the applicant. If this part is partially or totally completed by the applicant or altered, the form <u>will not</u> be accepted. Complete dates in form of month/day/year are required where indicated.**

A. NAME OF MEDICAL SCHOOL ADDRESS CITY, STATE COUNTRY/PROVIDENCE

B. DATES OF ATTENDANCE - **EACH YEAR** MUST BE LISTED SEPARATELY. DO NOT GROUP DATES OF ATTENDANCE.

**<u>1st year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>2nd year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>3rd year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>4th year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>5th year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>6th year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**<u>7th year</u>**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

INTERNSHIP YEAR, IF APPLICABLE
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

C. BASIC SCIENCE COURSES

**Anatomy**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Physiology**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Biochemistry**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Microbiology/Immunology**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Pathology**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Pharmacology/Therapeutics**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

**Preventative Medicine**
From __ __ / __ __ / __ __ __ __ (Month / Day / Year) To __ __ / __ __ / __ __ __ __ (Month / Day / Year)

D. INDICATE LENGTH OF ACADEMIC YEAR _____ MONTHS. DATE MEDICAL DEGREE WAS CONFERRED __ __ / __ __ / __ __ __ __ (Month / Day / Year)

NAME (Last, First, MI):

SS#:

Profession:

E. CORE CLERKSHIP ROTATIONS.

COMPLETE DATES IN THE FORM OF MONTH/DAY/YEAR ARE REQUIRED. EACH ROTATION MUST BE A MINIMUM OF FOUR (4) WEEKS IN LENGTH AND COMPLETED WHILE ENROLLED IN THE MEDICAL COLLEGE CONFERRING DEGREE. CORE ROTATIONS WILL NOT BE ACCEPTED OR CO-VALIDATED FROM ANOTHER MEDICAL SCHOOL. (MPA Section 11 (A)(2).)

**Internal Medicine Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Pediatrics Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Obstetrics/Gynecology Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Surgery Rotation**
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

**Psychiatry Rotation****
Started:____ /____ /____ Completed:____ /____ /____
Total WEEKS spent in clinical training rotation:_____
Facility Name:_____
City/State/Country:_____
Check **ONE**:
- ☐ Government owned/operated facility
- ☐ Medical school owned/operated facility
- ☐ Written Affiliation/Contract with facility
- ☐ Verbal Affiliation

** The 4 week psychiatry core clerkship rotation may be completed as follows: 2 weeks must be completed formally and distinctly in psychiatry as verified by the medical school on this form. The other 2 weeks may be completed in other clinical rotations as verified by the applicant's affidavit. Contact the Division for the *Affidavit of Psychiatry Core Clerkship Rotations* form.

I hereby certify that the information above is true and accurate to the records of this medical college and in accordance with Section 11 (A)(2) of the Medical Practice Act and Section 1285.20 of the Administrative Rules. I further certify that the applicant received a medical degree from and was enrolled in this college at the time the core rotations were completed; that the core clinical clerkship rotations were conducted in the clinical teaching facilities either **owned or operated by this medical college; government owned or operated;** OR **formally affiliated or contracted;** OR **held a verbal affiliation agreement** with this medical college. In the case of a written agreement, it is certified that all affiliation agreements were in full effect at the time of the applicant's rotation and evaluations verifying passage of each core clerkship rotation were submitted by the supervising physician.

SEAL OF COLLEGE

_____
Signature of Dean of Medical College

_____
Print Name of Dean of Medical College

_____
Date Completed

_____
Printed Name of Medical College

**RETURN THIS FORM TO APPLICANT**

**PLEASE TYPE OR PRINT IN BLACK INK ONLY.**

IMPORTANT NOTICE: Completion of this form is necessary to accomplish the requirements outlined in 225 ILCS 60/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# ILLINOIS DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION

# AFFIDAVIT OF PSYCHIATRY CORE CLERKSHIP ROTATIONS

APPLICANT: This form is to be utilized to verify 2-weeks of psychiatry during another clinical rotation when the medical college has certified to completion of 2-weeks formally and distinctly of a **psychiatry rotation**. Form must be notarized.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ Month Day Year

4. SOCIAL SECURITY NUMBER __ __ __ – __ __ – __ __ __ __

OR CONTACT ID NUMBER FROM IDFPR ACKNOWLEDGEMENT LETTER __ __ __ __ __ __ __ __ __

5. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

☐ Permanent Physician 036
☐ Temporary Physician 125

## *AFFIDAVIT OF PSYCHIATRY CORE CLERKSHIP ROTATIONS*

This is to certify that while enrolled in medical college, I completed four (4) weeks of psychiatry core clerkship rotations. I further certify that of the four (4) weeks completed, at least two (2) of the four (4) weeks were obtained solely and distinctly in psychiatry; and the other two (2) week requirement was included and completed in other clinical rotations and did not overlap with the four (4) week requirement in said other required rotations.

The additional two (2) weeks were completed in the following other clinical rotation(s):

Rotation(s) _____ _____

Location(s) _____ _____

Dates of Rotation(s) _____ _____

**CERTIFYING STATEMENT OF AFFIANT**

Under penalties of perjury, I declare that the information I have recorded herein is true and correct.

_____

Signature of Affiant

SUBSCRIBED AND SWORN TO me, this _____ day of _____ , 20___ .

_____

NOTARY PUBLIC STATE OF ILLINOIS COUNTY OF _____

**IMPORTANT NOTICE:** Completion of this form is necessary to accomplish the requirements outlined in 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

# VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY

SUPPORTING DOCUMENT

# VE-PC

1. NAME LAST FIRST MIDDLE

3. ADDRESS STREET, CITY, STATE, ZIP CODE

4. DATE OF BIRTH

__ __ / __ __ / __ __ __ __
Month Day Year

5. SOCIAL SECURITY NUMBER

__ __ __ - __ __ - __ __ __ __

2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:

| | Profession Code |
|---|---|
| ☐ Permanent Physician License | 036 |
| ☐ Temporary Physician Training License | 125 |
| ☐ Chiropractic Physician License | 038 |

6. TODAY'S DATE

**Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.**

A. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

B. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

C. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

D. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

E. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

F. NAME OF PRACTICE / WORK LOCATION

JOB TITLE

ADDRESS STREET, CITY, STATE, ZIP CODE

DESCRIPTION OF DUTIES PERFORMED

DATE OF EMPLOYMENT/ATTENDANCE

From __ __ / __ __ / __ __ __ __
Month Day Year

To __ __ / __ __ / __ __ __ __
Month Day Year

HOURS WORKED PER WEEK

TYPE OF EMPLOYMENT

☐ Full-time ☐ Part-time

TOTAL TIME WORKED (Year/Month)

NAME (Last, First, MI):

SS#:

Profession: