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