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.	**CERTIFICATE OF HEALTH**	SUPPORTING DOCUMENT **HL**

APPLICANT: Complete the applicant section of this form. The physician who examines you MUST hold an active license in the jurisdiction in which he/she practices. Direct the physician to complete the Examining Physician Section of this form and return the completed form to you for inclusion with your Application for Licensure and/or Examination.

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

EXAMINING PHYSICIAN: Complete the remainder of this form. Reference the above profession name to determine the appropriate statement to check-off. Return the completed form to the applicant. Physical examination must have occurred within the preceeding 12 months.

A. PHYSICIAN NAME FIRST MIDDLE LAST	B. PHYSICIAN LICENSE NUMBER
C. STREET ADDRESS	D. STATE OR TERRITORY OF LICENSURE
E. CITY, STATE, ZIP CODE	F. DATES OF APPLICANT'S PHYSICAL EXAMINATION OR IMMUNIZATION

STATEMENT I: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

NURSING HOME ADMINISTRATOR

The above-named applicant is of sound physical and mental health. ☐ Yes ☐ No

STATEMENT II: COMPLETE THIS STATEMENT FOR THE PROFESSION OF:

FUNERAL DIRECTOR AND EMBALMER

The above-named applicant received the following: 1) Diptheria-Tetanus (adult type) immunizations ☐ Series ☐ Booster
2) Hepatitis B ☐ Series

I hereby declare that the above information is true and correct.

_____ Signature

_____ Date