

<b>IMPORTANT NOTICE:</b> 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.	<b>VERIFICATION OF EMPLOYMENT / EXPERIENCE-- PROFESSIONAL CAPACITY</b>	SUPPORTING DOCUMENT  <b>VE-PC</b>
<b>APPLICANT:</b> <i>Complete the application section of this form, then forward it to your employer. Upon receipt of the completed form from the employer, include it with your Application for Licensure/Examination. You are authorized to photocopy this form as necessary.</i>		
1. NAME      LAST                      FIRST                      MIDDLE	2. PLEASE CHECK THE TYPE OF LICENSE FOR WHICH YOU ARE APPLYING:	
3. ADDRESS    STREET, CITY, STATE, ZIP CODE	<div style="text-align: right;"><u>Profession Code</u></div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <span><input type="checkbox"/> Permanent Physician License</span> <span>036</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> Temporary Physician Training License</span> <span>125</span> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <span><input type="checkbox"/> Chiropractic Physician License</span> <span>038</span> </div>	
4. DATE OF BIRTH ____ / ____ / ____ Month    Day    Year	6. MAIDEN OR GIVEN SURNAME	
5. SOCIAL SECURITY NUMBER ____ - ____ - ____		
<b>Record work history chronologically for the five (5) years preceding the date of application beginning with present employment.</b>		
A. NAME OF BUSINESS / INSTITUTION		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 <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
TOTAL TIME WORKED (Year/Month)		
B. NAME OF BUSINESS / INSTITUTION		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 <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time		
TOTAL TIME WORKED (Year/Month)		