State of Illinois Department of Human Services
Division of Developmental Disabilities

ILLINOIS HEALTH CARE WORKER REGISTRY APPLICATION FORM

(Please type or print legibly)

Applicant Information

Name: ______________________ ______________________ __________
Last *First* *Middle*

Date of Birth: ______________ **Social Security Number:** _____ - _____ - _____
Month / Day / Year

Address: ____ __________
Street Address / P.O. Box / Rural Route *Apt.*

______________________________ __________ __________
City *State* *Zip Code*

Telephone Number: _____ - _____ - _____ **Program Code:** ______________

Program Completion Date: ______________
Month / Day / Year

Optional Information

Race
- ☐ Asian / Pacific Islander
- ☐ American Indian / Alaskan Native
- ☐ White
- ☐ Black
- ☐ Unknown

Sex
- ☐ Male
- ☐ Female

Eye Color
- ☐ Blue
- ☐ Green
- ☐ Brown
- ☐ Hazel

Height _____ (feet) _____ (inches)

Consent to Place Information on Registry

Your signature on this application certifies that the information provided is accurate and grants permission to the State of Illinois and any affiliate acting on the behalf of the State of Illinois to place information from this form on the Illinois Care Worker Registry.

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Signature