State of Illinois
Illinois Department of Healthcare and Family Services

Psychiatric Residency Certification

This certification pertains only to the relationship of the Illinois Department of Healthcare and Family Services with the provider in the provision of telepsychiatry services and group psychotherapy services.

Section A: Provider Information

Name	Provider #	NPI

Office Address	City	State	Zip

Office Phone	Fax Number

Section B: Residency Program Information

I have completed the following residency programs: (Check all that apply)

☐ **General Psychiatric Residency**

Residency Program: _____

_____

Date Program Completed: _____

☐ **Child/Adolescent Psychiatric Residency**

Residency Program: _____

_____

Date Program Completed: _____

Section C: Certification

Under penalties of perjury, the undersigned declares that the information provided above is true, correct and complete.

_____ _____

Provider Signature Date

_____

Printed name of signature above

Print Form