State of Illinois Department of Children and Family Services **REQUEST FOR ASSIGNMENT OF LICENSE PERSONNEL ID**

Complete and submit to:		Date Submitted		
-	of Children and Family Servi	ices		
0	al Office – Licensing Unit			
5415 North U	niversity St., Ste. 103	FAX #: (309) 693-4	937	
Peoria, Illinois	s 61614-4738	PHONE: (309) 693-	-5400	
<u> PLEASE PRINT LEGIBLY – FORM</u>	WILL BE RETURNED I	FALL INFORMATION I	S NOT PROVIDED	
Name of Licensing Worker:				
	(Last)	(First)	(Middle Initial)	

Office Address:					
(Street)		(City)		(Zip Code)	
Telephone # (Work)	/	<u> </u>	Language(s):		
Licensing Worker is: DCFS Worker: R/S/F:	OR	Private Agency Wo Agency Name: _	orker:	Agency II)#
			Do you currently use this nnel ID# <u>if you no longer need it fo</u>		_
Current Title:			Date Current Title Became Ef	ffective:	
Date of Employment: _					
Supervisor's Name:			Supervisor's License Pers	sonnel ID#:	
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Licensing Personnel ID# Assigned: