# SB3920

LRB10418708BDA32151b

## 104TH GENERAL ASSEMBLY

## State of Illinois

## 2025 and 2026

### SB3920

Introduced 2/6/2026, by Sen. Andrew S. Chesney

## SYNOPSIS AS INTRODUCED:

New Act
225 ILCS 60/22

Creates the Youth Health Protection Act. Provides that a medical doctor shall not prescribe, provide, administer, or deliver puberty-suppressing drugs or cross-sex hormones and shall not perform surgical orchiectomy or castration, urethroplasty, vaginoplasty, mastectomy, phalloplasty, or metoidioplasty on biologically healthy and anatomically normal persons under the age of 18 for the purpose of treating the subjective, internal psychological condition of gender dysphoria or gender discordance. Provides that any efforts to modify the anatomy, physiology, or biochemistry of a biologically healthy person under the age of 18 who experiences gender dysphoria or gender discordance shall be considered unprofessional conduct and shall be subject to discipline by the licensing entity or disciplinary review board. Provides that no medical doctor or mental health provider shall refer any person under the age of 18 to any medical doctor for chemical or surgical interventions to treat gender dysphoria or gender discordance. Contains definitions, a statement of purpose, and legislative findings. Amends the Medical Practice Act of 1987 to make related changes.

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A BILL FOR

AN ACT concerning regulation.

**Be it enacted by the People of the State of Illinois, represented in the General Assembly:**

Section 1. Short title. This Act may be cited as the Youth Health Protection Act.

Section 5. Legislative findings. The General Assembly finds and declares the following:

(1) At birth, doctors identify the sex of babies. They do not assign them a "gender."

(2) Being biologically male or biologically female is not a disorder, illness, deficiency, shortcoming, or error. Scientists and other medical professionals have recognized that biological sex is a neutral, objective, and immutable fact of human nature.

(3) Puberty is not a disease or a disorder.

(4) There is no conclusive, research-based evidence proving that if there is incongruence between one's objective and immutable biological sex (and its attendant healthy and normally functioning anatomy and physiology) and one's subjective, internal sense of being male or female that the problem resides in the body rather than the mind.

(5) The May 19, 2014 issue of the highly respected Hayes Directory reports that the practice of using hormones and

surgery to treat gender dysphoria in adults is based on "very low quality of evidence" and goes on to discuss the "serious limitations to the evidence" in great detail. It reports further that the use of hormones and surgery to treat gender dysphoria in children and adolescents has no evidence base.

(6) Health risks and complications of puberty suppression: The use of puberty-suppression medications for the treatment of gender-dysphoric minors is "off-label." The health risks include the arrest of bone growth, a decrease in bone accretion, the prevention of sex-steroid-dependent organization and maturation of the adolescent brain, and the inhibition of fertility by preventing the development of gonadal tissue and mature gametes for the duration of treatment.

(7) Self-fulfilling nature of puberty suppression: "There is an obvious self-fulfilling nature to encouraging a young boy with [gender dysphoria] to socially impersonate a girl and then institute pubertal suppression. Given the well-established phenomenon of neuroplasticity, the repeated behavior of impersonating a girl alters the structure and function of the boy's brain in some way-potentially in a way that will make identity alignment with his biologic sex less likely. This, together with the suppression of puberty that prevents further endogenous masculinization of his brain, causes him to remain a gender non-conforming prepubertal boy disguised as a prepubertal girl."

(8) Cross-sex hormones risks and effects: The use of cross-sex hormones for the treatment of gender dysphoria in minors is "off-label," and long-term risks are unknown.

Sterility and voice changes are permanent for both men and women.

An interagency statement published by the World Health Organization states that "sterilization should only be provided with the full, free and informed consent of the individual" and that "sterilization refers not just to interventions where the intention is to limit fertility ... but also to situations where loss of fertility is a secondary outcome. ... Sterilization without full, free and informed consent has been variously described by international, regional and national human rights bodies as an involuntary, coercive and/or forced practice, and as a violation of fundamental human rights, including the right to health, the right to information, the right to privacy."

Since parents or guardians must provide consent for hormonal interventions, and since parents and guardians are not being made aware of the experimental nature of the off-label use of hormones for the treatment of gender dysphoria or of the fact that most children with gender dysphoria outgrow it by late adolescence if otherwise supported through natural puberty, parents and guardians are unable to provide fully informed consent.

Breast tissue growth in men who take estrogen is

permanent. "Male"-pattern baldness and body and facial hair growth in women who take testosterone are permanent.

For biologically healthy men who take estrogen to treat their subjective, internal feelings about their sex, there is an "increased risk of liver disease, increased risk of blood clots, (risk of death or permanent damage), increased risk of diabetes and of headaches/migraines heart disease, increased risk of gallstones, may be increased risk of noncancerous [tumor] of pituitary gland."

For biologically healthy women who take testosterone to treat their subjective, internal feelings about their sex, there is an increased risk of heart disease, stroke, diabetes, breast cancer, ovarian cancer, and uterine cancer. Taking testosterone can have a "destabilizing effect" on "bipolar disorder, schizoaffective disorder, and schizophrenia."

(9) The Christian Medical and Dental Associations "[believe] that prescribing hormonal treatments to children or adolescents to disrupt normal sexual development for the purpose of gender reassignment is ethically impermissible, whether requested by the child or the parent."

(10) The Catholic Medical Association "urges health care professionals to adhere to genetic science and sexual complementarity over ideology in the treatment of gender dysphoria (GD) in children. This includes especially avoiding puberty suppression and the use of cross-sex hormones in children with GD. One's sex is not a social construct, but an

unchangeable biological reality."

(11) Surgery (e.g., mastectomy and orchiectomy) is irreversible.

(12) Teen brain: Neuroscientist, Professor of Neurology at the University of Pennsylvania, and author of The Teenage Brain, Dr. Frances Jensen, explains that:

Teenagers do have frontal lobes, which are the seat of our executive, adult-like functioning like impulse control, judgment and empathy. But the frontal lobes haven't been connected with fast-acting connections yet. ...

But there is another part of the brain that is fully active in adolescents, and that's the limbic system. And that is the seat of risk, reward, impulsivity, sexual behavior and emotion.

So they are built to be novelty-seeking at this point in their lives.

(13) Suicide rate: The oft-cited suicide rate of 41% for those who identify as "trans" is based on an erroneous understanding of a study by the Williams Institute, an understanding that ignores the acknowledged and serious limitations of the study.

(14) There is no evidence that surgery or chemical disruption of normal, natural, and healthy development or processes reduces the incidence of suicide.

(15) Dr. J. Michael Bailey, Professor of Psychology at Northwestern University, and Dr. Raymond Blanchard, former

psychologist in the Adult Gender Identity Clinic of Toronto's Centre for Addiction and Mental Health (CAMH) from 1980-1995 and the Head of CAMH's Clinical Sexology Services from 1995-2010, have written the following:

(a) Children (most commonly, adolescents) who threaten to commit suicide rarely do so, although they are more likely to kill themselves than children who do not threaten suicide.

(b) Mental health problems, including suicide, are associated with some forms of gender dysphoria. But suicide is rare even among gender dysphoric persons.

(c) There is no persuasive evidence that gender transition reduces gender dysphoric children's likelihood of suicide.

(d) The idea that mental health problems, including suicidality, are caused by gender dysphoria rather than the other way around (i.e., mental health and personality issues cause a vulnerability to experience gender dysphoria) is currently popular and politically correct. It is, however, unproven and as likely to be false as true.

(16) There is no phenomenon of women trapped in men's bodies or vice versa, or of men having women's brains or vice versa: Science has not proven that the brains of transgender individuals are "wired differently" than others with the same biological sex. In other words, there is no conclusive evidence of a "female brain" being contained in a male body or

vice versa. In fact, it is impossible for an opposite sexed brain to be "trapped" in the wrong body. Every brain cell of a male fetus has a Y chromosome; female fetal brains do not. This makes their brains forever intrinsically different. Additionally, at 8 weeks gestation, male fetuses have every cell of their body, including every brain cell, bathed by a testosterone surge secreted by their testes. Female fetuses lack testes; none of their cells, including their brain cells, experience this endogenous testosterone surge. [Reyes FI, Winter JS, Faiman C. "Studies on human sexual development Fetal gonadal and adrenal sex steroids"; J Clin Endocrinol Metab. 1973 Jul; 37(1):74-8; Lombardo, M. "Fetal Testosterone Influences Sexually Dimorphic Gray Matter in the Human Brain"; The Journal of Neuroscience, 11 January 2012, 32(2); Campano, A. [ed]. Geneva Foundation for Medical Education and Research: human sexual differentiation (2016).]

(17) Brain-sex theories: "[C]urrent studies on associations between brain structure and transgender identity are small, methodologically limited, inconclusive, and sometimes contradictory. Even if they were more methodologically reliable, they would be insufficient to demonstrate that brain structure is a cause, rather than an effect, of the gender-identity behavior. They would likewise lack predictive power, the real challenge for any theory in science."

(18) Desistance: The best research to date suggests that

without social or medical "transition" most (60-90%) gender-dysphoric children will come to accept their biological sex after passing naturally through puberty. While "12-27% of 'gender variant' children persist in gender dysphoria; that percentage rises to 40% amongst those who visit gender clinics." Research shows that desistance rates rise significantly among those who are given puberty-blockers and "gender-affirmative psychotherapy," thus suggesting that such interventions lead minors "to commit more strongly to sex reassignment than they might have if they had received a different diagnosis or a different course of treatment."

(19) The American College of Pediatricians confirms what "detransitioners" assert: There are many possible post-natal, environmental causes for gender dysphoria:

Family and peer relationships, one's school and neighborhood, the experience of any form of abuse, media exposure, chronic illness, war, and natural disasters are all examples of environmental factors that impact an individual's emotional, social, and psychological development.

(20) Autism: "Mounting evidence over the last decade points to increased rates of autism spectrum disorders (ASD) and autism traits among children and adults with gender dysphoria, or incongruence between a person's experienced or expressed gender and the gender assigned to them at birth. ... It is possible that some of the psychological characteristics common in children with ASD-including cognitive deficits,

tendencies toward obsessive preoccupations, or difficulties learning from other people-complicate the formation of gender identity."

(21) A study published in May 2018 "further confirmed a possible association between ASD and the wish to be of the opposite gender by establishing increased endorsement of this wish in adolescents and adults with ASD compared to the general population controls."

(22) "Rapid-onset gender dysphoria" (ROGD): Dr. J. Michael Bailey, Professor of Psychology at Northwestern University, and Dr. Raymond Blanchard, former psychologist in the Adult Gender Identity Clinic of Toronto's Centre for Addiction and Mental Health (CAMH) from 1980-1995 and the Head of CAMH's Clinical Sexology Services from 1995-2010, explain the phenomenon of ROGD:

The typical case of ROGD involves an adolescent or young adult female whose social world outside the family glorifies transgender phenomena and exaggerates their prevalence. Furthermore, it likely includes a heavy dose of internet involvement. The adolescent female acquires the conviction that she is transgender. (Not uncommonly, others in her peer group acquire the same conviction.) These peer groups encouraged each other to believe that all unhappiness, anxiety, and life problems are likely due to their being transgender, and that gender transition is the only solution. Subsequently, there may be a rush towards gender transition.

... We believe that ROGD is a socially contagious phenomenon in which a young person-typically a natal female-comes to believe that she has a condition that she does not have. ROGD is not about discovering gender dysphoria that was there all along; rather, it is about falsely coming to believe that one's problems have been due to gender dysphoria previously hidden (from the self and others). Let us be clear: People with ROGD do have a kind of gender dysphoria, but it is gender dysphoria due to persuasion of those especially vulnerable to a false idea.

(23) Brown University Researcher, Dr. Lisa Littman, conducted a survey of parents whose children developed Rapid Onset Gender Dysphoria. Littman wrote that the "worsening of mental well-being and parent-child relationships and behaviors that isolate [adolescents and young adults] from their parents, families, non-transgender friends and mainstream sources of information are particularly concerning. More research is needed to better understand this phenomenon, its implications and scope."

(24) The number of children "being referred for transitioning treatment" in England has increased 4,400% for girls and 1,250% for boys, which has resulted in calls from members of Parliament for an investigation.

(25) Body Integrity Identity Disorder (BIID) shares in common several features with gender dysphoria. BIID is a condition in which "[s]ufferers from BIID experience a

mismatch between their physically healthy body and the body with which they identify. They identify as disabled. They often desire a specific amputation to achieve the disabled body they want." As with some cases of gender dysphoria, scientists say there is evidence for neurological involvement as a cause of the experience of BIID, and yet physicians largely oppose elective amputations of healthy anatomical parts:

According to the principle of nonmaleficence physicians must not perform amputations without a medical indication because amputations bear great risks and often have severe consequences besides the disability ... for example, infections [or] thromboses. Even though some physicians perform harmful surgeries as breast enlargement surgeries, this cannot justify surgeries that are even more harmful. Even if amputations would be a possible therapy for BIID, they would be risky experimental therapies that could be justified only if they promised lifesaving or the cure of severe diseases and if an alternative therapy would not be available. At least the first condition is not fulfilled in the case of BIID, and probably the second is not fulfilled either. Above all, an amputation causes an irreversible damage that could not be healed, even if the patient's body image would be restored spontaneously or through a new therapy. ... But since all psychiatrists who have investigated BIID patients found that the amputation desire is either obsessive or based on a

monothematic delusion, and since neurological studies support the hypothesis of a brain disorder (which is also supported by the most influential advocates of elective amputations), elective amputations have to be regarded as severe bodily injuries of patients.

(26) The American College of Pediatricians (ACPeds), "a national medical association of licensed physicians and healthcare professionals who specialize in the care of infants, children, and adolescents" that split from the American Academy of Pediatrics because of its politicization of the practice of medicine, describes puberty-suppression, cross-sex hormone, and surgeries variously referred to as sex-change, sex reassignment, gender reassignment and gender confirmation surgeries as child abuse."

(27) Dr. Lisa Simons, pediatrician at Robert H. Lurie Children's Hospital of Chicago, stated in a PBS Frontline documentary that "'The bottom line is we don't really know how sex hormones impact any adolescent's brain development.' ... What's lacking, she said, are specific studies that look at the neurocognitive effects of puberty blockers."

(28) Dr. Kenneth Zucker, one of the world's leading authorities on gender dysphoria, states that:

"Identity is a process. It is complicated. It takes a long period of time ... to know who a child really is. ... There are different pathways that can lead to gender dysphoria. ... It's an intellectual and clinical mistake to think that there's one

single cause that explains all gender dysphoria. ... Just because little kids say something doesn't necessarily mean that you accept it, or that it's true, or that it's in the best interest of the child. ... Little kids can present with extreme gender dysphoria, but that doesn't mean they're all going to grow up to continue to have gender dysphoria.

(29) Dr. Eric Vilain, a geneticist at UCLA who specializes in sexual development and sex differences in the brain, says the studies on twins are mixed and that, on the whole, "there is no evidence of a biological influence on transsexualism yet."

(30) Sheila Jeffreys, lesbian feminist scholar, warns against the "transgendering" of children: "Those who do not conform to correct gender stereotypes are being sterilized and they're being sterilized as children."

(31) Heather Brunskell-Evans Heather, social theorist, philosopher, and Senior Research Fellow at King's College, London, UK, and Michele Moore, Professor of Inclusive Education and Editor-in-Chief of the world-leading journal Disability & Society, critique the "transgender" ideology:

[O]ur central contention is that transgender children don't exist. Although we argue that 'the transgender child' is a fabrication, we do not disavow that some children and adolescents experience gender dysphoria and that concerned and loving parents will do anything to alleviate their children's distress. It is because of children's bodily discomfort that

we argue it is important families and support services are informed by appropriate models for understanding gender. Our analysis of transgenderism demonstrates it is a new phenomenon, since dissatisfaction with assigned gender takes different forms in different historical contexts. The 'transgender child' is a relatively new historical figure, brought into being by a coalition of pressure groups, political activists and knowledge makers. ... Bizarrely, in transgender theory, biology is said to be a social construct but gender is regarded as an inherent property located 'somewhere' in the brain or soul or other undefined area of the body. We reverse these propositions with the concept that it is gender, not biology, which is a social construct. From our theoretical perspective, the sexed body is material and biological, and gender is the externally imposed set of norms that prescribe and proscribe desirable [behaviors] for children. Our objection to transgenderism is that it confines children to traditional views about gender.

(32) Stephanie Davies-Arias, writer, communication skills expert, and pediatric transition critic, writes that "changing your sex to match your 'gender identity' reinforces the very stereotypes which [transgender organizations] claim to be challenging ... as, in increasing numbers, boys who love princess culture become 'girls' and short-haired football-loving girls become 'boys'. Promoted as a 'progressive' social justice movement based on 'accepting

difference', transgender ideology in fact takes that difference and stamps it out. It says that the sexist stereotypes of 'gender' are the true distinction between boys and girls and biological sex is an illusion."

(33) Sex-change regret/De-transitioning: Increasing numbers of young men and women experience "sex-change regret" and are "detransitioning." Unfortunately, some effects of "medical transitions" are irreversible. A BBC documentary titled "Luke" includes a young biological woman who regrets taking cross-sex hormones and having a double mastectomy at age 20 and shares her experience.

Section 10. Purpose. The purpose of this Act is to protect gender-dysphoric, gender-discordant, and gender-non-conforming minors or minors who experience rapid onset gender dysphoria from medical procedures or the off-label use of chemicals that have not been studied for these purposes and that permanently alter anatomy, biochemistry, or physiology.

The State has a moral duty and legal right to step in and regulate medical practices that are found in violation of the principles that inhere in the Nuremberg Code, including the principle that experiments should be based on previous knowledge (e.g., an expectation derived from animal experiments) that justifies the experiment.

Section 15. Definitions. As used in this Act:

"Biological sex" means a person's objective, immutable biological sex, which may be understood according to the following: In biology, an organism is male or female if it is structured to perform one of the respective roles in reproduction. This definition does not require any arbitrary measurable or quantifiable physical characteristics or behaviors; it requires understanding the reproductive system and the reproduction process. Different animals have different reproductive systems, but sexual reproduction occurs when the sex cells from the male and female of the species come together to form newly fertilized embryos. It is these reproductive roles that provide the conceptual basis for the differentiation of animals into the biological categories of male and female. There is no other widely accepted biological classification for the sexes.

"Desistance" means the tendency for gender dysphoria to resolve itself as a child gets older and older.

"Detransition" means the process by which someone who has been identifying as the opposite sex, presenting himself or herself as the opposite sex, taking cross-sex hormones, and may or may not have had surgery rejects his or her "trans" identity and accepts his or her objective, immutable biological sex.

"Gender" means the psychological, behavioral, social, and cultural aspects of being male or female.

"Gender dysphoria" means one's persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

"Gender identity" means one's sense of oneself as male, female, or transgender. "Gender identity" also means one's innermost concept of self as male, female, a blend of both male and female, or neither male nor female.

Section 20. Prohibition on treatment of persons under the age of 18 for gender dysphoria or gender discordance.

(a) A medical doctor shall not prescribe, provide, administer, or deliver puberty-suppressing drugs or cross-sex hormones and shall not perform surgical orchiectomy or castration, urethroplasty, vaginoplasty, mastectomy, phalloplasty, or metoidioplasty on biologically healthy and anatomically normal persons under the age of 18 for the purpose of treating the subjective, internal psychological condition of gender dysphoria or gender discordance.

(b) Any efforts to modify the anatomy, physiology, or biochemistry of a biologically healthy person under the age of 18 who experiences gender dysphoria or gender discordance shall be considered unprofessional conduct and shall be subject to discipline by the licensing entity or disciplinary review board with competent jurisdiction.

(c) No medical doctor or mental health provider shall refer any person under the age of 18 to any medical doctor for

chemical or surgical interventions to treat gender dysphoria or gender discordance.

Section 90. The Medical Practice Act of 1987 is amended by changing Section 22 as follows:

(225 ILCS 60/22)

(Section scheduled to be repealed on January 1, 2027)

Sec. 22. Disciplinary action.

(A) The Department may revoke, suspend, place on probation, reprimand, refuse to issue or renew, or take any other disciplinary or non-disciplinary action as the Department may deem proper with regard to the license or permit of any person issued under this Act, including imposing fines not to exceed $10,000 for each violation, upon any of the following grounds:

(1) (Blank).

(2) (Blank).

(3) A plea of guilty or nolo contendere, finding of guilt, jury verdict, or entry of judgment or sentencing, including, but not limited to, convictions, preceding sentences of supervision, conditional discharge, or first offender probation, under the laws of any jurisdiction of the United States of any crime that is a felony.

(4) Gross negligence in practice under this Act.

(5) Engaging in dishonorable, unethical, or

unprofessional conduct of a character likely to deceive, defraud, or harm the public.

(6) Obtaining any fee by fraud, deceit, or misrepresentation.

(7) Habitual or excessive use or abuse of drugs defined in law as controlled substances, of alcohol, or of any other substances which results in the inability to practice with reasonable judgment, skill, or safety.

(8) Practicing under a false or, except as provided by law, an assumed name.

(9) Fraud or misrepresentation in applying for, or procuring, a license under this Act or in connection with applying for renewal of a license under this Act.

(10) Making a false or misleading statement regarding their skill or the efficacy or value of the medicine, treatment, or remedy prescribed by them at their direction in the treatment of any disease or other condition of the body or mind.

(11) Allowing another person or organization to use their license, procured under this Act, to practice.

(12) Adverse action taken by another state or jurisdiction against a license or other authorization to practice as a medical doctor, doctor of osteopathy, doctor of osteopathic medicine, or doctor of chiropractic, a certified copy of the record of the action taken by the other state or jurisdiction being prima facie evidence

thereof. This includes any adverse action taken by a State or federal agency that prohibits a medical doctor, doctor of osteopathy, doctor of osteopathic medicine, or doctor of chiropractic from providing services to the agency's participants.

(13) Violation of any provision of this Act or of the Medical Practice Act prior to the repeal of that Act, or violation of the rules, or a final administrative action of the Secretary, after consideration of the recommendation of the Medical Board.

(14) Violation of the prohibition against fee splitting in Section 22.2 of this Act.

(15) A finding by the Medical Board that the registrant after having his or her license placed on probationary status or subjected to conditions or restrictions violated the terms of the probation or failed to comply with such terms or conditions.

(16) Abandonment of a patient.

(17) Prescribing, selling, administering, distributing, giving, or self-administering any drug classified as a controlled substance (designated product) or narcotic for other than medically accepted therapeutic purposes.

(18) Promotion of the sale of drugs, devices, appliances, or goods provided for a patient in such manner as to exploit the patient for financial gain of the

physician.

(19) Offering, undertaking, or agreeing to cure or treat disease by a secret method, procedure, treatment, or medicine, or the treating, operating, or prescribing for any human condition by a method, means, or procedure which the licensee refuses to divulge upon demand of the Department.

(20) Immoral conduct in the commission of any act, including, but not limited to, commission of an act of sexual misconduct related to the licensee's practice.

(21) Willfully making or filing false records or reports in his or her practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Healthcare and Family Services (formerly Department of Public Aid) under the Illinois Public Aid Code.

(22) Willful omission to file or record, or willfully impeding the filing or recording, or inducing another person to omit to file or record, medical reports as required by law, or willfully failing to report an instance of suspected abuse or neglect as required by law.

(23) Being named as a perpetrator in an indicated report by the Department of Children and Family Services under the Abused and Neglected Child Reporting Act, and upon proof by clear and convincing evidence that the licensee has caused a child to be an abused child or

neglected child as defined in the Abused and Neglected Child Reporting Act.

(24) Solicitation of professional patronage by any corporation, agents, or persons, or profiting from those representing themselves to be agents of the licensee.

(25) Gross, ~~and~~ willful, and continued overcharging for professional services, including filing false statements for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Healthcare and Family Services (formerly Department of Public Aid) under the Illinois Public Aid Code.

(26) A pattern of practice or other behavior which demonstrates incapacity or incompetence to practice under this Act.

(27) Mental illness or disability which results in the inability to practice under this Act with reasonable judgment, skill, or safety.

(28) Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice under this Act with reasonable judgment, skill, or safety.

(29) Cheating on or attempting to subvert the licensing examinations administered under this Act.

(30) Willfully or negligently violating the confidentiality between physician and patient except as required by law.

(31) The use of any false, fraudulent, or deceptive statement in any document connected with practice under this Act.

(32) Aiding and abetting an individual not licensed under this Act in the practice of a profession licensed under this Act.

(33) Violating State or federal laws or regulations relating to controlled substances, legend drugs, or ephedra as defined in the Ephedra Prohibition Act.

(34) Failure to report to the Department any adverse final action taken against them by another licensing jurisdiction (any other state or any territory of the United States or any foreign state or country), by any peer review body, by any health care institution, by any professional society or association related to practice under this Act, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(35) Failure to report to the Department surrender of a license or authorization to practice as a medical doctor, a doctor of osteopathy, a doctor of osteopathic medicine, or doctor of chiropractic in another state or

jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society, while under disciplinary investigation by any of those authorities or bodies, for acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(36) Failure to report to the Department any adverse judgment, settlement, or award arising from a liability claim related to acts or conduct similar to acts or conduct which would constitute grounds for action as defined in this Section.

(37) Failure to provide copies of medical records as required by law.

(38) Failure to furnish the Department, or its investigators or representatives, relevant information~~,~~ legally requested by the Department after consultation with the Chief Medical Coordinator or the Deputy Medical Coordinator.

(39) Violating the Health Care Worker Self-Referral Act.

(40) (Blank).

(41) Failure to establish and maintain records of patient care and treatment as required by this law.

(42) Entering into an excessive number of written collaborative agreements with licensed advanced practice registered nurses resulting in an inability to adequately

collaborate.

(43) Repeated failure to adequately collaborate with a licensed advanced practice registered nurse.

(44) Violating the Compassionate Use of Medical Cannabis Program Act.

(45) Entering into an excessive number of written collaborative agreements with licensed prescribing psychologists resulting in an inability to adequately collaborate.

(46) Repeated failure to adequately collaborate with a licensed prescribing psychologist.

(47) Willfully failing to report an instance of suspected abuse, neglect, financial exploitation, or self-neglect of an eligible adult as defined in and required by the Adult Protective Services Act.

(48) Being named as an abuser in a verified report by the Department on Aging under the Adult Protective Services Act, and upon proof by clear and convincing evidence that the licensee abused, neglected, or financially exploited an eligible adult as defined in the Adult Protective Services Act.

(49) Entering into an excessive number of written collaborative agreements with licensed physician assistants resulting in an inability to adequately collaborate.

(50) Repeated failure to adequately collaborate with a

physician assistant.

(51) Violating the Youth Health Protection Act.

Except for actions involving the ground numbered (26), all proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper, with regard to a license on any of the foregoing grounds, must be commenced within 5 years next after receipt by the Department of a complaint alleging the commission of or notice of the conviction order for any of the acts described herein. Except for the grounds numbered (8), (9), (26), and (29), no action shall be commenced more than 10 years after the date of the incident or act alleged to have violated this Section. For actions involving the ground numbered (26), a pattern of practice or other behavior includes all incidents alleged to be part of the pattern of practice or other behavior that occurred, or a report pursuant to Section 23 of this Act received, within the 10-year period preceding the filing of the complaint. In the event of the settlement of any claim or cause of action in favor of the claimant or the reduction to final judgment of any civil action in favor of the plaintiff, such claim, cause of action, or civil action being grounded on the allegation that a person licensed under this Act was negligent in providing care, the Department shall have an additional period of 2 years from the date of notification to the Department under Section 23 of this Act of such settlement or final judgment in which to investigate and commence formal

disciplinary proceedings under Section 36 of this Act, except as otherwise provided by law. The time during which the holder of the license was outside the State of Illinois shall not be included within any period of time limiting the commencement of disciplinary action by the Department.

The entry of an order or judgment by any circuit court establishing that any person holding a license under this Act is a person in need of mental treatment operates as a suspension of that license. That person may resume his or her practice only upon the entry of a Departmental order based upon a finding by the Medical Board that the person has been determined to be recovered from mental illness by the court and upon the Medical Board's recommendation that the person be permitted to resume his or her practice.

The Department may refuse to issue or take disciplinary action concerning the license of any person who fails to file a return, or to pay the tax, penalty, or interest shown in a filed return, or to pay any final assessment of tax, penalty, or interest, as required by any tax Act administered by the Illinois Department of Revenue, until such time as the requirements of any such tax Act are satisfied as determined by the Illinois Department of Revenue.

The Department, upon the recommendation of the Medical Board, shall adopt rules which set forth standards to be used in determining:

(a) when a person will be deemed sufficiently

rehabilitated to warrant the public trust;

(b) what constitutes dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud, or harm the public;

(c) what constitutes immoral conduct in the commission of any act, including, but not limited to, commission of an act of sexual misconduct related to the licensee's practice; and

(d) what constitutes gross negligence in the practice of medicine.

However, no such rule shall be admissible into evidence in any civil action except for review of a licensing or other disciplinary action under this Act.

In enforcing this Section, the Medical Board, upon a showing of a possible violation, may compel any individual who is licensed to practice under this Act or holds a permit to practice under this Act, or any individual who has applied for licensure or a permit pursuant to this Act, to submit to a mental or physical examination and evaluation, or both, which may include a substance abuse or sexual offender evaluation, as required by the Medical Board and at the expense of the Department. The Medical Board shall specifically designate the examining physician licensed to practice medicine in all of its branches or, if applicable, the multidisciplinary team involved in providing the mental or physical examination and evaluation, or both. The multidisciplinary team shall be led

by a physician licensed to practice medicine in all of its branches and may consist of one or more or a combination of physicians licensed to practice medicine in all of its branches, licensed chiropractic physicians, licensed clinical psychologists, licensed clinical social workers, licensed clinical professional counselors, and other professional and administrative staff. Any examining physician or member of the multidisciplinary team may require any person ordered to submit to an examination and evaluation pursuant to this Section to submit to any additional supplemental testing deemed necessary to complete any examination or evaluation process, including, but not limited to, blood testing, urinalysis, psychological testing, or neuropsychological testing. The Medical Board or the Department may order the examining physician or any member of the multidisciplinary team to provide to the Department or the Medical Board any and all records, including business records, that relate to the examination and evaluation, including any supplemental testing performed. The Medical Board or the Department may order the examining physician or any member of the multidisciplinary team to present testimony concerning this examination and evaluation of the licensee, permit holder, or applicant, including testimony concerning any supplemental testing or documents relating to the examination and evaluation. No information, report, record, or other documents in any way related to the examination and evaluation shall be excluded by

reason of any common law or statutory privilege relating to communication between the licensee, permit holder, or applicant and the examining physician or any member of the multidisciplinary team. No authorization is necessary from the licensee, permit holder, or applicant ordered to undergo an evaluation and examination for the examining physician or any member of the multidisciplinary team to provide information, reports, records, or other documents or to provide any testimony regarding the examination and evaluation. The individual to be examined may have, at his or her own expense, another physician of his or her choice present during all aspects of the examination. Failure of any individual to submit to mental or physical examination and evaluation, or both, when directed, shall result in an automatic suspension, without hearing, until such time as the individual submits to the examination. If the Medical Board finds a physician unable to practice following an examination and evaluation because of the reasons set forth in this Section, the Medical Board shall require such physician to submit to care, counseling, or treatment by physicians, or other health care professionals, approved or designated by the Medical Board, as a condition for issued, continued, reinstated, or renewed licensure to practice. Any physician, whose license was granted pursuant to Section 9, 17, or 19 of this Act~~,~~ or, continued, reinstated, renewed, disciplined, or supervised, subject to such terms, conditions, or restrictions who shall fail to comply with such

terms, conditions, or restrictions, or to complete a required program of care, counseling, or treatment, as determined by the Chief Medical Coordinator or Deputy Medical Coordinators, shall be referred to the Secretary for a determination as to whether the licensee shall have his or her license suspended immediately, pending a hearing by the Medical Board. In instances in which the Secretary immediately suspends a license under this Section, a hearing upon such person's license must be convened by the Medical Board within 15 days after such suspension and completed without appreciable delay. The Medical Board shall have the authority to review the subject physician's record of treatment and counseling regarding the impairment, to the extent permitted by applicable federal statutes and regulations safeguarding the confidentiality of medical records.

An individual licensed under this Act, affected under this Section, shall be afforded an opportunity to demonstrate to the Medical Board that he or she can resume practice in compliance with acceptable and prevailing standards under the provisions of his or her license.

The Medical Board, in determining mental capacity of an individual licensed under this Act, shall consider the latest recommendations of the Federation of State Medical Boards.

The Department may promulgate rules for the imposition of fines in disciplinary cases, not to exceed $10,000 for each violation of this Act. Fines may be imposed in conjunction

with other forms of disciplinary action, but shall not be the exclusive disposition of any disciplinary action arising out of conduct resulting in death or injury to a patient. Any funds collected from such fines shall be deposited in the Illinois State Medical Disciplinary Fund.

All fines imposed under this Section shall be paid within 60 days after the effective date of the order imposing the fine or in accordance with the terms set forth in the order imposing the fine.

(B) The Department shall revoke the license or permit issued under this Act to practice medicine of a chiropractic physician who has been convicted a second time of committing any felony under the Illinois Controlled Substances Act or the Methamphetamine Control and Community Protection Act, or who has been convicted a second time of committing a Class 1 felony under Sections 8A-3 and 8A-6 of the Illinois Public Aid Code. A person whose license or permit is revoked under this subsection (B) shall be prohibited from practicing medicine or treating human ailments without the use of drugs and without operative surgery.

(C) The Department shall not revoke, suspend, place on probation, reprimand, refuse to issue or renew, or take any other disciplinary or non-disciplinary action against a person's authorization to practice under this Act:

(1) based solely upon the recommendation of the person to an eligible patient regarding, or prescription for, or

treatment with, an investigational drug, biological product, or device;

(2) for experimental treatment for Lyme disease or other tick-borne diseases, including, but not limited to, the prescription of or treatment with long-term antibiotics;

(3) based solely upon the person providing, authorizing, recommending, aiding, assisting, referring for, or otherwise participating in any health care service, so long as the care was not unlawful under the laws of this State, regardless of whether the patient was a resident of this State or another state; or

(4) based upon the person's license, registration, or permit being revoked or suspended, or the person being otherwise disciplined, by any other state if that revocation, suspension, or other form of discipline was based solely on the person violating another state's laws prohibiting the provision of, authorization of, recommendation of, aiding or assisting in, referring for, or participation in any health care service if that health care service as provided would not have been unlawful under the laws of this State and is consistent with the applicable standard of conduct for the person practicing in Illinois under this Act.

(D) (Blank).

(E) The conduct specified in subsection (C) shall not

trigger reporting requirements under Section 23, constitute grounds for suspension under Section 25, or be included on the physician's profile required under Section 10 of the Patients' Right to Know Act.

(F) An applicant seeking licensure, certification, or authorization pursuant to this Act and who has been subject to disciplinary action by a duly authorized professional disciplinary agency of another jurisdiction solely on the basis of having provided, authorized, recommended, aided, assisted, referred for, or otherwise participated in health care shall not be denied such licensure, certification, or authorization, unless the Department determines that the action would have constituted professional misconduct in this State; however, nothing in this Section shall be construed as prohibiting the Department from evaluating the conduct of the applicant and making a determination regarding the licensure, certification, or authorization to practice a profession under this Act.

(G) The Department may adopt rules to implement, administer, and enforce this Section ~~Public Act 102-1117~~.

(Source: P.A. 103-442, eff. 1-1-24; 104-417, eff. 8-15-25; 104-432, eff. 1-1-26; revised 9-15-25.)