

## Information Bulletin: Opioid Alternative Pilot Program Physician Registration Step-by-Step

<https://icts.illinois.gov>

Physicians can register to the ICTS web site from the Illinois Cannabis Tracking System Sign In page.

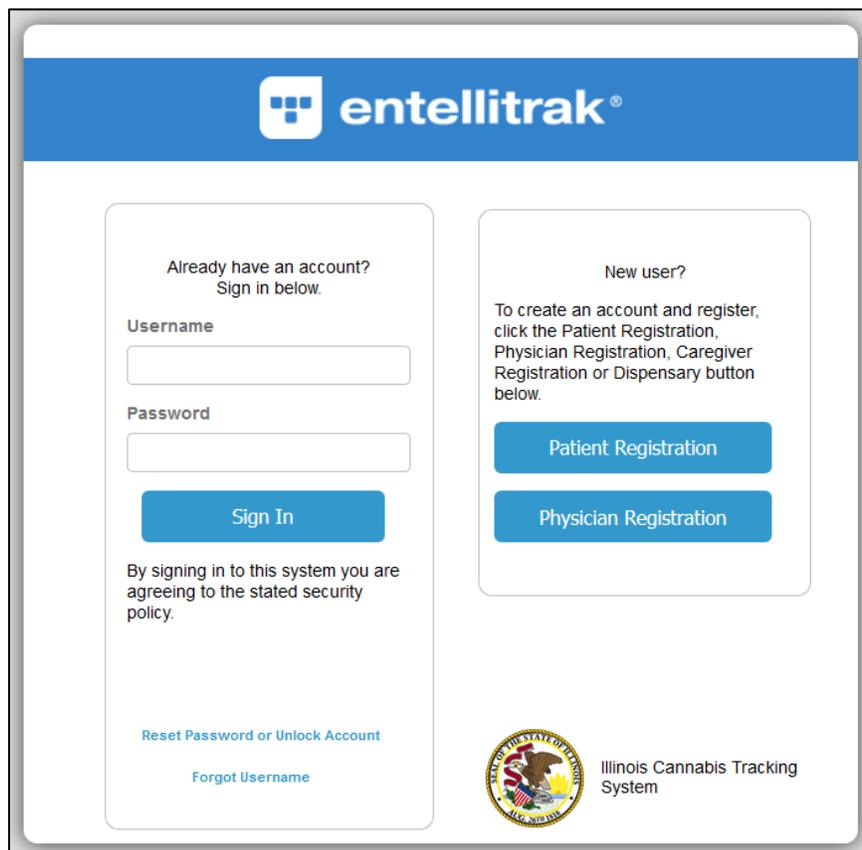
### Creating Sign In Information

The first step in registering to ICTS is to create Sign In information on the ICTS web site.

To create Sign In information:

1. Access the Illinois Cannabis Tracking System web site.

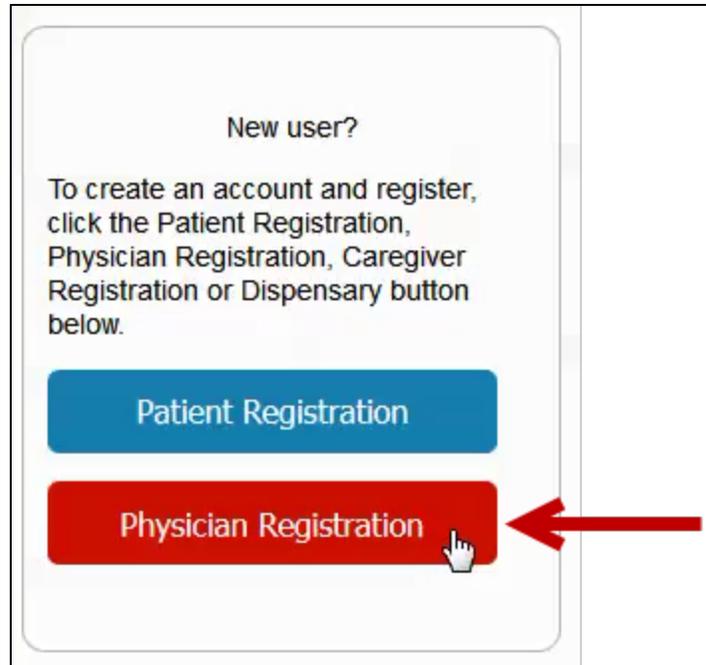
The Sign In/Registration page appears.



The screenshot shows the 'entellitrak' login and registration interface. It features a blue header with the 'entellitrak' logo. Below the header, there are two main sections: 'Already have an account?' and 'New user?'. The 'Already have an account?' section includes fields for 'Username' and 'Password', a 'Sign In' button, and links for 'Reset Password or Unlock Account' and 'Forgot Username'. The 'New user?' section includes instructions on how to register and two buttons: 'Patient Registration' and 'Physician Registration'. At the bottom right, there is a circular seal for the State of Illinois and the text 'Illinois Cannabis Tracking System'.

**Figure A: Sign In popup and New user section**

Click the Patient and Physician Registration button.



**Figure B: Physician Registration**

In the User Information page, enter your Email Address, First Name, Last Name and Username, and Physician PIN.

**Registration Type**  
Physician

**User Information**

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Direct Email Address (The email address entered here should be your direct email address that no one else besides you has access to. Do not enter an email address that is shared with other providers or office staff)

R

**First Name**

R

**Middle Initial**

**Last Name**

R

**Username**

R

Please create a 4-digit PIN. This number should be unique to you, and will be required each time you issue a Physician Certification.

**Physician PIN**

R

**Figure C: User Information popup**

Complete the Physician – Proof of Identity section.

**Physician - Proof of Identity**

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Please provide your valid and current Illinois Driver's License or Illinois ID Card information:

**Driver's License/State ID Number**

R

**Driver's ID/State ID Upload**

Illinois Drivers License.jpg R

**Date of Birth**

R

**Figure D: Physician - Proof of Identity section**

Throughout the page, use the Calendar tool to select dates or simply type the date.

**IL Controlled Substance License Expiration Date**

**December 2024**

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

**Figure E: Calendar selector**

Complete the Physician – Provider Credentials section.

**Physician - Provider Credentials**

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**National Provider ID Number**

R

**IL Physician's License Number**

R

**IL Controlled Substances License Number**

R

**Figure F: Physician – Provider Credentials section**

Physician – Office Contact Information section.

<b>Physician - Office Contact Information</b>	
<b>Office Address</b>	<input type="text" value="700 S. Wabash"/> 
<b>Office Apt/Suite/Floor/PO Box</b>	<input type="text" value="Suite 187"/>
<b>Office City</b>	<input type="text" value="Chicago"/> 
<b>Office State</b>	<input type="text" value="IL"/> 
<b>Office County</b>	<input type="text" value="Cook"/> 
<b>Office Zip Code</b>	<input type="text" value="60605"/> 
<b>Office Phone (The phone number entered here should be main number to your practice)</b>	<input type="text" value="(747) 304-1190"/> 
<b>Direct Phone (The phone number entered here should be your direct line or cell number. Do not enter a phone number to your main practice where someone other than you will answer the line)</b>	<input type="text" value="(747) 304-1192"/> 
<b>General Office Email Address (The email address entered here should be an email that is shared with other provider or office staff to receive information)</b>	<input type="text" value="acochrane@bedr.com"/> 

**Figure G: Physician Office Contact Information**

Read the Confidentiality Agreement and enter your name in the Electronic Signature box.

**Physician - Confidentiality Agreement**

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*I hereby certify that I have verified the above information to be accurate and complete and no one other than me is submitting this request.  
I authorize the Illinois Department of Public Health, Medical Cannabis Pilot Program to contact me using the telephone number and email address I provided. I understand incomplete applications will not be accepted.*

**Electronic Signature**

Amos Cochrane Ⓜ

Register Cancel

**Figure H: Electronic Signature**

Click the Register button.

**Electronic Signature**

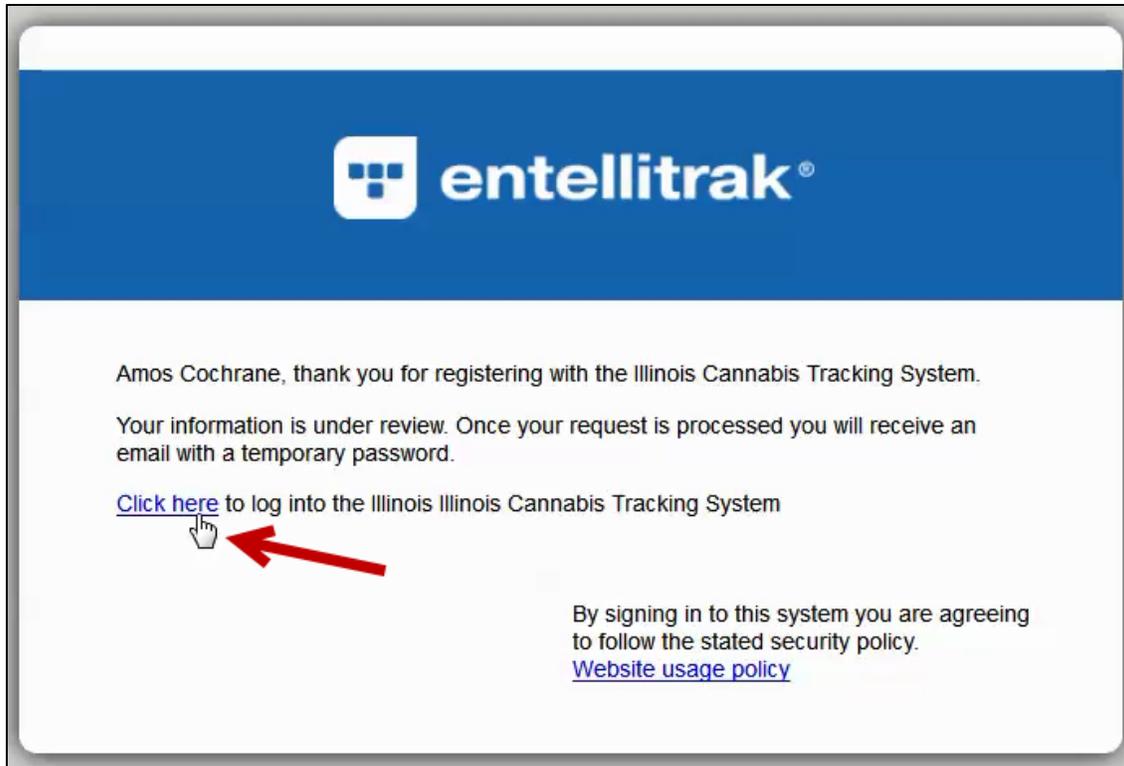
Amos Cochrane Ⓜ

Register Cancel



**Figure I: Register button**

A Confirmation window appears.



**Figure J: Confirmation window**

An email is sent to you.

Follow the instructions in the email.

In the email message, click the *Click here* link.

The Sign In/Registration page opens. Enter your Username and the Password.