IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED

APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.

1. NAME LAST FIRST MIDDLE

2. DATE OF BIRTH __ __ / __ __ / __ __ __ __ (Month Day Year)

3. SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __

4. ADDRESS STREET, CITY, STATE, ZIP CODE

5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.

Profession Name ____________ Profession Code ___ ___ ___

6. MAIDEN OR GIVEN SURNAME

7. NAME OF INSTITUTION ATTENDED

8. DATE OF GRADUATION / COMPLETION __ __ / __ __ / __ __ __ __ (Month Day Year)

I hereby authorize a school official of the institution named above to furnish to the Illinois Department of Financial and Professional Regulation or its designated testing service the information requested below.

Date ____________ Signature of Applicant ____________

SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side. RETURN THE COMPLETED FORM TO THE APPLICANT.

A. NAME OF INSTITUTION
University of Illinois at Springfield

B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
One University Plaza MS BRK 332
Springfield IL 62703-5407

C. DEPARTMENT OF INSTITUTION
Human Development Counseling

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT
Clinical Mental Health Counseling

E. MAJOR AREA OF STUDY OF THE APPLICANT
Human Development Counseling:
Clinical Mental Health Counseling

F. APPLICANT WAS (CHECK ONE):
☐ Full-time ☐ Part-time ☐ Co-op

G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
☐ ________ Semester Hours
☐ ________ Quarter Hours
☐ ________ Course Hours

H. DATES OF ATTENDANCE
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (Month Day Year)

I. Total academic years attended _____ Years _____ Months _____ Days
OR
Total calendar years attended _____ Years _____ Months _____ Days

J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., M.D., Ph.D.)

K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET __ __ / __ __ / __ __ __ __ (Month Day Year)

L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED __ __ / __ __ / __ __ __ __ (Month Day Year)

M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE

☐ Applicant has graduated on __ __ / __ __ / __ __ __ __ (Month Day Year)
☐ Applicant has completed program on __ __ / __ __ / __ __ __ __ (Month Day Year)
☐ Applicant will graduate on __ __ / __ __ / __ __ __ __ (Month Day Year)
☐ Applicant will complete program on __ __ / __ __ / __ __ __ __ (Month Day Year)

N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

I certify that the information recorded herein is true and correct according to the official records of this institution.

Print Name of School Official

Signature of School Official

Title

Date

SCHOOL SEAL OR NOTARY SEAL

NOTE: If the institution does not have a school seal, this form must be notarized.

Subscribed and sworn before me this _____ day of _______________ , 20____.

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.

NAME (Last, First, MI):

SS#:

Profession: