

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. <div style="text-align: center;"> _____ Profession Name _____ Profession Code </div>	
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 Marriage, Couple and Family Counseling
E. MAJOR AREA OF STUDY OF THE APPLICANT Human Development Counseling: Marriage, Couple and Family Counseling	F. APPLICANT WAS (CHECK ONE): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Co-op
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) <input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Quarter Hours <input type="checkbox"/> _____ Course Hours	H. DATES OF ATTENDANCE From ___/___/___ To ___/___/___ Month Day Year 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 <input type="checkbox"/> Applicant has graduated on ___/___/___ <input type="checkbox"/> Applicant has completed program on ___/___/___ Month Day Year Month Day Year <input type="checkbox"/> Applicant will graduate on ___/___/___ <input type="checkbox"/> Applicant will complete program on ___/___/___ Month Day Year 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.

NAME (Last, First, MI):

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

SS#:

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____.

Profession:

Date of Expiration

Signature of Notary Public

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.