IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 85/1 et. seq. (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 - PHM

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.

6. MAIDEN OR GIVEN SURNAME

_____ ___ ___ ___
Profession Name Profession Code

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, then return to the applicant.***

A. NAME OF INSTITUTION

B. ADDRESS OF INSTITUTION (STREET, CITY, STATE, ZIP CODE)

C. DEPARTMENT OF INSTITUTION

D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT

E. MAJOR AREA OF STUDY OF THE APPLICANT

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

G. TOTAL CREDIT HOURS EARNED (CHECK ONE AND COMPLETE.)
☐ _____ Semester Hours ☐ _____ Quarter Hours ☐ _____ 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., Ph.D.)

K. 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

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

M. NUMBER OF CLOCK HOURS OF SUPERVISED CLINICAL PHARMACY, CLERKSHIP OR EXTERNSHIP EXPERIENCE FOR WHICH ACADEMIC CREDIT WAS ISSUED:

Clock Hours _____

N. THE APPLICANT'S FIRST PROFESSIONAL PHARMACY DEGREE PROGRAM HAS BEEN ACCREDITED BY:

☐ The American Council on Pharmaceutical Education

☐ Other: _____

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

P. WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION.

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 _____ , _____.

_____ _____

Date of Expiration | Signature of Notary Public

RETURN THIS FORM TO APPLICANT

NAME (Last, First, MI):

SS#:

Profession: