

**IMPORTANT NOTICE:** Completion of this form is necessary for consideration for licensure under 225 ILCS 90/1 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 - PT

**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  4. ADDRESS      STREET, CITY, STATE, ZIP CODE  6. MAIDEN OR GIVEN SURNAME  7. NAME OF INSTITUTION ATTENDED	2. DATE OF BIRTH ____ / ____ / ____ Month      Day      Year  3. SOCIAL SECURITY NUMBER ____ - ____ - ____  5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.  <div style="display: flex; justify-content: space-between;"> <span>_____ Profession Name</span> <span>_____ Profession Code</span> </div> 8. DATE OF GRADUATION / COMPLETION ____ / ____ / ____ Month      Day      Year
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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  C. DEPARTMENT OF INSTITUTION  E. MAJOR AREA OF STUDY OF THE APPLICANT  G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) <input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Quarter Hours <input type="checkbox"/> _____ Course Hours	B. ADDRESS OF INSTITUTION      STREET, CITY, STATE, ZIP CODE  D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT  F. APPLICANT WAS (CHECK ONE): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Co-op
I. Total academic years attended _____ OR      Years      Months      Days Total calendar years attended _____ Years      Months      Days	H. DATES OF ATTENDANCE  From ____ / ____ / ____ To ____ / ____ / ____ Month      Day      Year      Month      Day      Year
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  <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Applicant has graduated on ____ / ____ / ____             Month      Day      Year         </div> <div> <input type="checkbox"/> Applicant has completed program on ____ / ____ / ____             Month      Day      Year         </div> </div> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Applicant will graduate on ____ / ____ / ____             Month      Day      Year         </div> <div> <input type="checkbox"/> Applicant will complete program on ____ / ____ / ____             Month      Day      Year         </div> </div>

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

## O. PRE-PROFESSIONAL UNDERGRADUATE EDUCATION

NAME OF INSTITUTION	DATES OF ATTENDANCE ____/____/____ Month Day Year	CREDIT HOURS <input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Course Hours
LOCATION (City and State)	____/____/____ Month Day Year	<input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Course Hours
NAME OF INSTITUTION	DATES OF ATTENDANCE ____/____/____ Month Day Year	CREDIT HOURS <input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Course Hours
LOCATION (City and State)	____/____/____ Month Day Year	<input type="checkbox"/> _____ Semester Hours <input type="checkbox"/> _____ Course Hours

P. 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

**ATTENTION APPLICANT: FOR INCLUSION  
WITH THE APPLICATION PACKET.**