

<p><b>IMPORTANT NOTICE:</b> Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.</p>	<h2 style="margin: 0;">CERTIFICATION OF EDUCATION</h2>	<p style="margin: 0;">SUPPORTING DOCUMENT</p> <h1 style="margin: 0;">ED-NUR</h1>
<p><b>APPLICANT: Complete the applicant section of this form, then forward it to the school for completion of the remainder of the form.</b></p>		
<p>1. NAME      LAST              FIRST              MIDDLE</p>	<p>2. DATE OF BIRTH</p> <p>___ / ___ / ___</p> <p style="text-align: center;">Month      Day      Year</p>	<p>3. SOCIAL SECURITY NUMBER</p> <p>___ - ___ - ____</p>
<p>4. ADDRESS      STREET              CITY              STATE      ZIP CODE</p>	<p>5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.</p>	
<p>6. MAIDEN OR GIVEN SURNAME</p>	<p style="text-align: center;">_____</p> <p style="text-align: center;">Profession Name                      Profession Code</p>	
<p>7. NAME OF INSTITUTION ATTENDED</p>	<p>8. DATE OF GRADUATION/COMPLETION</p> <p>___ / ___ / ___</p> <p style="text-align: center;">Month      Day      Year</p>	
<p>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.</p>		
<p style="text-align: center;">_____</p> <p style="text-align: center;">Date    Signature of Applicant</p>		
<p><b>SCHOOL OFFICIAL: Complete the bottom portion of this page and the reverse side, then return to the applicant.</b></p>		
<p>A. NAME OF INSTITUTION</p>	<p>B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE</p>	
<p>C. DEPARTMENT OF INSTITUTION</p>		
<p>D. MAJOR AREA OF STUDY OF THE APPLICANT</p>	<p>E. DATES OF ATTENDANCE</p> <p>From ___ / ___ / ___ To ___ / ___ / ___</p> <p style="text-align: center;">Month      Day      Year              Month      Day      Year</p>	
<p>F. Total academic years attended      ___ / ___ / ___</p> <p style="text-align: center;">Years      Months      Days</p> <p style="text-align: center;"><b>OR</b></p> <p>Total calendar years attended      ___ / ___ / ___</p> <p style="text-align: center;">Years      Months      Days</p>	<p>G. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., BA., MA., Ph.D.)</p>	
<p>H. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET</p> <p>___ / ___ / ___</p> <p style="text-align: center;">Month      Day      Year</p>	<p>I. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED</p> <p>___ / ___ / ___</p> <p style="text-align: center;">Month      Day      Year</p>	
<p>J. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE NORMALLY REQUIRED TIME, PLEASE EXPLAIN:</p>		

K. NURSING SCHOOL PROGRAM CODE

NCSBN Number    \_ \_ - \_ \_ \_

**SUBMISSION OF THIS FORM PRIOR TO PROGRAM COMPLETION WILL RESULT IN ITS RETURN TO THE PROGRAM FOR CORRECTION.**

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

\_\_\_\_\_  
Print Name of Dean or Director of Nursing

\_\_\_\_\_  
License Number

\_\_\_\_\_  
Signature of Dean or Director of Nursing

\_\_\_\_\_  
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

**RETURN THIS FORM TO APPLICANT**

NAME (Last, First, MI):

SS#:

Profession: