

IMPORTANT NOTICE: 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.

CERTIFICATION OF EDUCATION

SUPPORTING DOCUMENT

ED-NUR

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="display: flex; justify-content: space-between;"> 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, then return to the applicant.

A. NAME OF INSTITUTION	B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE
C. DEPARTMENT OF INSTITUTION	E. DATES OF ATTENDANCE From ___ / ___ / ___ To ___ / ___ / ___ Month Day Year Month Day Year
D. MAJOR AREA OF STUDY OF THE APPLICANT	
F. Total academic years attended ___ / ___ / ___ Years Months Days OR Total calendar years attended ___ / ___ / ___ Years Months Days	G. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., BA., MA., Ph.D.)
H. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET ___ / ___ / ___ Month Day Year	I. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED ___ / ___ / ___ Month Day Year

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

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: