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

FOR CTS EXAM USE ONLY

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.

Profession Name _____ Profession Code ___ ___ ___

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.

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. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE)
☐ _____ Semester Hours
☐ _____ Quarter Hours
☐ _____ Course Hours

H. DATES OF ATTENDANCE
From __ __ / __ __ / __ __ __ __ (Month Day Year) To __ __ / __ __ / __ __ __ __ (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

☐ 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)

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):

SS#:

Profession:

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

SCHOOL OFFICIAL: RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT - RETURN THIS FORM TO:

CONTINENTAL TESTING SERVICES, INC.
P.O. BOX 100
LaGrange, ILLINOIS 60525-0100