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.

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 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. MAJOR AREA OF STUDY OF THE APPLICANT

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

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 __ __ - __ __ __

NAME (Last, First, MI):

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

SS#:

RETURN THIS FORM TO APPLICANT

Profession: