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 PROFESSIONAL COUNSELORS

SUPPORTING DOCUMENT

ED - PC

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. SSN OR ITIN __ __ __ - __ __ - __ __ __ __
4. ADDRESS STREET, CITY, STATE, ZIP CODE	5. PROFESSION (Mark only ONE): ☐ **Licensed Professional Counselor (178)** ☐ **Licensed Clinical Professional Counselor (180)**	
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. RETURN THE COMPLETED FORM TO THE APPLICANT.

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., M.A., M.D., Psy.D., Ph.D., None)
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. THE PROGRAM WAS ACCREDITED BY THE COUNCIL FOR ACCREDITATION OF COUNSELING AND RELATED EDUCATIONAL PROGRAMS (CACREP), THE COUNCIL FOR REHABILITATION EDUCATION (CORE), OR THE AMERICAN PSYCHOLOGICAL ASSOCIATION (APA) AT THE TIME THE PROGRAM WAS COMPLETED. ☐ YES ☐ NO

P. In the table below, list GRADUATE LEVEL coursework completed by the applicant in each of the required core areas. Include BOTH the UNIT of credit and the AMOUNT of credit awarded. For Semester Hours, abbreviate "SH". For Quarter Hours, abbreviate "QH". For all other units of credit please include information about conversion to semester hours. (_____ = 3 semester hours.)

Do not include courses that do not fit the required core areas. If no course was completed in a specific core area, mark "NONE". If no credit was awarded, mark "ZERO".

Please refer to Rules 68 IAC Section 1375.Appendix A for more information about each core area.

Attach additional pages if necessary. Failure to complete this section of the application correctly may result in licensure delays for the applicant.

AREA	YEAR	COURSE NO.	COURSE TITLE	CREDIT AWARDED
Human Growth and Development				
Counseling Theory				
Counseling Techniques				
Group Dynamics, Processing and Counseling				
Appraisal of Individuals (Assessment)				
Research and Evaluation				
Professional, Legal & Ethical Responsibilities				
Social and Cultural Foundations				
Lifestyle and Career Development				
Practicum / Internship*				
* Completed at least 700 clock hours on-site including at least 280 hours direct client service.				YES / NO
Maladaptive Behavior & Psychopathology				
Addictions / Substance Abuse				
Family Dynamics				

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

NAME (Last, First, MI):

SSN OR ITIN:

Profession: