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

	then forward it to the school for completion of the remainder		
of the form.			
1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH 3. SSN OR ITIN		
	//		
4. ADDRESS STREET, CITY, STATE, ZIP CODE	Month Day Year  5. PROFESSION (Mark only ONE):		
4. ADDITEOS STREET, STIT, STATE, ZII SODE	5. The Ecolor (walk only of VE).		
	☐ Licensed Professional Counselor (178)		
6. MAIDEN OR GIVEN SURNAME	☐ Licensed Clinical Professional Counselor (180)		
7. NAME OF INSTITUTION ATTENDED	B. DATE OF GRADUATION / COMPLETION		
TO THE OF THE PROPERTY AND EAST	. Brill of Globornion, committee		
	// Month Day Year		
I hereby authorize a school official of the institution named ab	pove to furnish to the Illinois Department of Financial and		
Professional Regulation or its designated testing service the			
Troisesional regulation of its designated testing corries the	mormanon roquesteu selem		
Date	Signature of Applicant		
SCHOOL OFFICIAL: Complete the bottom portion of this	nage and the reverse side RETURN THE COMPLETED		
FORM TO THE APPLICANT.	page and the reverse side. RETORRETTIE COMILECTED		
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		
	AFFLICANI		
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 Semester Hours	H. DATES OF ATTENDANCE		
COMPLETE) Quarter Hours	From / / To / /		
Course Hours	Month Day Year Month Day Year		
Total academic years attended	J. TYPE OF DEGREE OR CERTIFICATE AWARDED		
I. Total academic years attended	(e.g., M.A., M.D., Psy.D., Ph.D., None)		
Total calendar years attended			
Years Months Days			
K. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET	L. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED		
/ / /	Month Day Year		
M. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE	I Month Day Tour		
· · ·	Applicant has completed program on 1 1		
Applicant has graduated on / / /	Applicant has completed program on////		
-	Applicant will complete program on/ / /		
Month Day Year	Month Day Year		
N. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE	NORMALLY REQUIRED TIME, PLEASE EXPLAIN:		

NAME
(Last,
First,
<u>M</u> ):

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						
Trint Name of Scrioo Official						
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						