IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 of the Illinois Complied 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**

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.	
6. MAIDEN OR GIVEN SURNAME	Profession Name	Profession Code
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
Lindenwood University	**209 South Kingshighway, St. Charles, MO 63301**
C. DEPARTMENT OF INSTITUTION **Professional & School Counseling**	D. SPECIFIC PROGRAM OR CURRICULUM CONCENTRATION OF APPLICANT **Professional Counseling**
E. MAJOR AREA OF STUDY OF THE APPLICANT **Professional Counseling**	F. APPLICANT WAS (CHECK ONE): ☐ Full-time ☐ Part-time ☐ Co-op
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) ☒ 48 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.) **M.A.**
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: