IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 85/1 et. seq. (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 - PHM

APPLICANT: Complete the applicant section of this form, of the form.	then forward it to the school for completion of the remainder		
1. NAME LAST FIRST MIDDLE	2. DATE OF BIRTH 3. SOCIAL SECURITY NUMBER		
4. ADDRESS STREET, CITY, STATE, ZIP CODE	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		
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 p	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. 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. TOTAL CREDIT HOURS EARNED (CHECK ONE AND COMPLETE.)	H. DATES OF ATTENDANCE		
Semester Hours Quarter Hours Course Hours	From To Month Day Year Month Day Year		
I. Total academic years attended OR Years Months Days Total calendar years attended Years Months Days Years Months Days	J. TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., B.A., M.A., Ph.D.)		
K. CHECK THE APPROPRIATE STATEMENT(S) AND COMPLETE Applicant has graduated on	Applicant has completed program on		
Applicant will graduate on	Applicant will complete program on		
L. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN TH	E NORMALLY REQUIRED TIME, PLEASE EXPLAIN:		

NAME
(Last,
First,
MI):

CO.	
'n	
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M. NUMBER OF CLOCK HOURS OF SUPERVISED CLINICAL PHARMACY, CLERKSHIP OR EXTERNSHIP EXPERIENCE FOR WHICH ACA- DEMIC CREDIT WAS ISSUED:			
Clock Hours			
N. THE APPLICANT'S FIRST PROFESSIONAL PHARMACY DEGREE PROGRAM HAS BEEN ACCREDITED BY:			
The American Council on Pharma	aceutical Education		
Other:			
O. USE THIS SPACE TO RECORD ANY OT THE APPLICANT'S EDUCATIONAL EXPE		DU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING	
D WHEN THE FORM IS SEPTIFIED DDIC	AD TO THE ACTUAL CDADUAT	TION OF THE APPLICANT THE COHOOL OFFICIAL IS	
P. WHEN THIS FORM IS CERTIFIED PRIOR TO THE ACTUAL GRADUATION OF THE APPLICANT, THE SCHOOL OFFICIAL IS RESPONSIBLE FOR NOTIFYING THE DEPARTMENT OF FINANCIAL AND PROFESSIONAL REGULATION OF ANY FAILURE ON THE PART OF THE APPLICANT TO COMPLETE THE REQUIREMENTS FOR GRADUATION.			
I certify that the information recorded herein is true and correct according to the official records of this institution.			
Print Name of School Of	fficial	Signature of School Official	
Title		Date	
Title		Date	
SCHOOL SEAL OR NOTARY SEAL	NOTE: If the institution d	does not have a school seal, this form must be notarized.	
	Subscribed and sworn be	efore me this, day of,,	
	Date of Expiration	Signature of Notary Public	
DETURN THE FORM TO ARRESTOANT			
RETURN THIS FORM TO APPLICANT			
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