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

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	3. SSN OR ITIN
Waddell Jonathan Edwin	11 / 30 / 1991 (Month / Day / Year)	4 3 1 - 8 1 - 3 7 4 7

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.
5804 Pelit Jean River Rd, North Lillle Rock, AR, 72116	Licensed Clinical Social Worker (Profession Name) — 1 4 9 (Profession Code)
6. MAIDEN OR GIVEN SURNAME	
7. NAME OF INSTITUTION ATTENDED: University of Arkansas at Little Rock	8. DATE OF GRADUATION / COMPLETION: 0 5 / 1 0 / 2 0 1 8 (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.

8/12/2024 (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., B.A., M.A., M.D., Ph.D.)
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 will graduate on ___/___/____ (Month / Day / Year)

☐ Applicant has completed program 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:

NAME (Last, First, MI):

O. USE THIS SPACE TO RECORD ANY OTHER INFORMATION THAT YOU FEEL WOULD ASSIST THE DEPARTMENT IN EVALUATING THE APPLICANT'S EDUCATIONAL EXPERIENCES.

SSN OR ITIN:

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

Profession:

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

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.