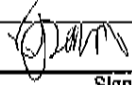


<b>IMPORTANT NOTICE:</b> Completion of this form is necessary for consideration for licensure under 225 of the Illinois Compiled Statutes. Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.		<b>CERTIFICATION OF EDUCATION</b>		SUPPORTING DOCUMENT  <b>ED</b>
<b>APPLICANT:</b> 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 Waddell Jonathan Edwin		2. DATE OF BIRTH 11 / 30 / 1991 Month Day Year		3. SSN OR ITIN 4 3 1 - 8 1 - 3 7 4 7
4. ADDRESS STREET, CITY, STATE, ZIP CODE 5804 Petit Jean River Rd, North Little Rock, AR, 72116		5. REFER TO REFERENCE SHEET. Record profession name and three digit profession code for which you are making Illinois application.  Licensed Clinical Social Worker      1 4 9 Profession Name      Profession Code		
6. MAIDEN OR GIVEN SURNAME		8. DATE OF GRADUATION / COMPLETION 05 / 10 / 2018 Month Day Year		
7. NAME OF INSTITUTION ATTENDED University of Arkansas at Little Rock		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		
<b>SCHOOL OFFICIAL:</b> 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): <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Co-op		
G. CREDIT HOURS EARNED (CHECK ONE AND COMPLETE) <input type="checkbox"/> Semester Hours <input type="checkbox"/> Quarter Hours <input type="checkbox"/> Course Hours		H. DATES OF ATTENDANCE From ___ / ___ / ___ To ___ / ___ / ___ Month Day Year      Month Day Year		
I. Total academic years attended 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 <input type="checkbox"/> Applicant has graduated on ___ / ___ / ___ <input type="checkbox"/> Applicant has completed program on ___ / ___ / ___ Month Day Year      Month Day Year <input type="checkbox"/> Applicant will graduate on ___ / ___ / ___ <input type="checkbox"/> 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, 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

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

Profession:

SCHOOL OFFICIAL RETURN THIS FORM TO APPLICANT

ATTENTION APPLICANT: FOR INCLUSION WITH THE APPLICATION PACKET.