IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 65/1 et.seq. of (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-NUR

APPLICANT: Complete the applicant section of this for remainder of the form.	m, then forward it to the school for completion of the		
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 / / Month Day Year		
I hereby authorize a school official of the institution named Professional Regulation or its designated testing service the	d above to furnish to the Illinois Department of Financial and the information requested below.		
Date	Signature of Applicant		
SCHOOL OFFICIAL: Complete the bottom portion of tapplicant.	this page and the reverse side, then return to the		
A. NAME OF INSTITUTION	B. ADDRESS OF INSTITUTION STREET, CITY, STATE, ZIP CODE		
C.DEPARTMENT OF INSTITUTION			
D.MAJOR AREA OF STUDY OF THE APPLICANT	E. DATES OF ATTENDANCE From / / To / / Month Day Year Month Day Year		
F. Total academic years attended OR Years Months Days Total calendar years attended Years Months Days	G.TYPE OF DEGREE OR CERTIFICATE AWARDED (e.g., BA., MA., Ph.D.)		
H. DATE THAT DEGREE OR CERTIFICATE REQUIREMENTS WERE MET	I. DATE THAT DEGREE OR CERTIFICATE WAS CONFERRED		
Month Day Year	Month Day Year		
J. IF EDUCATION PROGRAM WAS COMPLETED IN LESS THAN THE	NORMALLY REQUIRED TIME, PLEASE EXPLAIN:		

K. NURSING SCHOOL PROGRAM CODE						
NCSBN Number						
SUBMISSION OF THIS FORM PR PROGRAM FOR CORRECTION.	IOR TO PROGRAM COM	IPLETION WILL RE	SULT IN ITS RETU	RN TO THE		
I certify that the educational inform institution.	ation recorded herein is tr	rue and correct accor	rding to the official r	ecords of this		
Print Name of Dean or Director of Nursing	License Number	Signature	e of Dean or Director of I	Nursing		
Title	MELIANA (M. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.		Date	AAA La		
SCHOOL SEAL OR NOTARY SEAL	NOTE: If the institution	n does not have a sc	hool seal, this form	must be notarized.		
	Subscribed and swor	n before me this	day of	, 20		
	Date of Expiration		Signature of Notary	Public		
RETURN THIS FORM TO APPLICANT						