

CERTIFICATE OF PROFESSIONAL EDUCATION

TO BE COMPLETED BY THE APPLICANT. Please complete the top portion of this form; including your signature and date, and send to the appropriate educational institution where the professional degree was obtained.

Name of Applicant: _____

Address: _____

Social Security Number: _____ Date of Birth: _____

Date of Degree: _____ Degree: _____ Major: _____

Applicant's Signature: _____ Date: _____

TO BE COMPLETED BY THE EDUCATIONAL INSTITUTION. Return directly to: Bureau of Occupational Licenses attn: Carrie Gilstrap
Mailing address: PO Box 83720 Boise, ID 83720-0063. Physical address: 700 West State Street Boise, ID 83702

Dates of Attendance:	From (Date)	To (Date)
First Year		
Second Year		
Third Year		
Fourth Year		

As an authorized official of the named institution, I hereby certify that the above named applicant has completed all graduation requirements and has therefore been awarded such degree as is noted above.

Name of Educational Institution

City State Zip

Type or print your name

Institution Affiliation/Credentials

Your signature

Date

(SEAL)