



# Illinois State Board of Education

100 North First Street, E-240  
Springfield, Illinois 62777-0001



## STATE-APPROVED PROGRAM VERIFICATION FOR GIFTED EDUCATION SPECIALIST ONLY

### EDUCATOR EFFECTIVENESS DEPARTMENT

#### PART I - TO BE COMPLETED BY APPLICANT

An applicant applying for an Illinois license who has completed a state-approved program of preparation at a college or university shall use this form to verify completion of the program. The applicant should provide all information requested in Part I of this form. **Please request that the college/university email the completed form to [licensureforms@isbe.net](mailto:licensureforms@isbe.net). Forms submitted by the applicant or Regional Office of Education will not be honored.**

APPLICANT'S NAME (Last, First, Middle, Maiden)	IEIN	BIRTHDATE (mm/dd/yyyy)
ADDRESS (Street, City, State, ZIP Code)	TELEPHONE (Include Area Code)	
	EMAIL	

NAME OF COLLEGE/UNIVERSITY

ADDRESS (Street, City, State, ZIP Code)

TELEPHONE (Include Area Code)

#### PART II - TO BE COMPLETED ONLY BY THE COLLEGE/UNIVERSITY

Please verify that the above-named applicant has completed your state-approved program of preparation that, in your state, leads to a license comparable to gifted education specialist. **The licensure officer, registrar, or other authorized official should provide the information requested below and return the form to [licensureforms@isbe.net](mailto:licensureforms@isbe.net). Forms returned to the applicant or Regional Office of Education, will not be honored.**

#### AREA FOR WHICH APPLICATION IS BEING MADE

GIFTED EDUCATION SPECIALIST (PreK–Grade 12)

Yes  No The completed program included clinical experiences with five or more students in both prekindergarten through grade 8 and grades 9 through 12.

Yes  No For the purposes of the clinical experiences, the candidate has worked with at least one student enrolled in prekindergarten through grade 8 and at least one student enrolled in grades 9 through 12 and may have worked with a student one on one or in a group.

Yes  No The clinical experience included coaching and mentoring one or more teachers on the topic of gifted education.

NAME OF COLLEGE/UNIVERSITY	TELEPHONE (Include Area Code)
ADDRESS (Street, City, State, ZIP Code)	EMAIL

Yes  No *I certify that the applicant has completed all requirements of our approved program in effect at the time of the applicant's attendance for which recommendation is given.*

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Digital or Original* Signature of Authorized Official