Use your "Mouse" or "Tab" key to move through the fields and check boxes. After completing last field, save document to hard drive to make future updates or click print button.

Illinois State Board of Education

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

73-05G

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 e-mail the completed form to licensureforms@isbe.net. Forms returned to 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)	
	E-MAIL	

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. 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)	E-MAIL

☐ 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 _____ ***Original*** Signature of Authorized Official _____

Print Reset Form