OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION
Professional Certification
OLD CAPITOL BUILDING, PO BOX 47200
OLYMPIA WA 98504-7200
(360) 725-6400 TTY (360) 664-3631
Web Site: http:/ /www.k12.wa.us/certification/
E-Mail: cert@k12.wa.us

INSTITUTIONAL VERIFICATION OF PROGRAM COMPLETION AND CHARACTER

NOTE: Use this form ONLY if, in lieu of the ESA course, you are verifying completion of a state-approved program for certification for service specifically in a school setting.

Complete Section A, then send this form to the education (or appropriate) department of the college/university where you completed your educational staff associate preparation program. This form, when returned to you, is to be included with your application packet.

SECTION A TO BE COMPLETED BY APPLICANT

1. NAME LAST FIRST MIDDLE	MAIDEN/FORMER NAME
2. ADDRESS	3. DATE OF BIRTH
CITY/STATE/ZIP	4. SOCIAL SECURITY NO. (OPTIONAL)
5. TELEPHONE: BUSINESS ( ) HOME ( )	E-MAIL

SECTION B TO BE COMPLETED BY COLLEGE/UNIVERSITY

The above named is an applicant for certification in Washington State. Complete information in Section B regarding this applicant. To be valid, this form must be signed by the dean or certification officer of the college or the chair of the department at the institution where the applicant completed his/her preparation program. A stamped signature must be initialed by the person using the stamp. Verify the information with the school seal. RETURN THIS FORM TO THE APPLICANT.

A. This individual completed a program for the training of:

- ☐ School Nurse
- ☐ School Occupational Therapist
- ☐ School Physical Therapist
- ☐ School Social Worker
- ☐ School Speech-Language Pathologist or Audiologist

B. Date of program completion _____

School speech-language pathologist or audiologist ONLY:

C. Did the program include completion of a written comprehensive examination relevant to the role? ☐ YES ☐ NO

D. If the candidate did not earn a Master's degree with a major in speech-language pathology or audiology, did they complete all course work (except special project or thesis) for a Master's degree with a major in speech-language pathology or audiology?

☐ YES ☐ NO ☐ N/A

ALL ROLES:

E. Does your state require an educational certificate to serve in the specialized role identified in "A" above in the common schools (K–12) of your state? ☐ YES ☐ NO

F. Does the program the applicant completed have state approval for purposes of certification for serving in a K-12 school setting? ☐ YES ☐ NO

G. Was the applicant eligible to serve in the specialized role in the common schools in your state when he/she completed the program? ☐ YES ☐ NO

If no, what were the deficiencies? _____

H. What type of state certification, if any, was this applicant eligible to receive on completing your program? _____

I. Is there any reason you know of why this applicant should not be certified in Washington? If so, please explain: _____

NAME OF COLLEGE/UNIVERSITY	DATE	COLLEGE SEAL This form must bear the college/university seal.
ADDRESS		
CITY/STATE/ZIP		
TELEPHONE ( )	E-MAIL	
NAME (PRINTED) AND TITLE (Chairperson of Education Department/Certification Officer)		SIGNATURE

RETURN COMPLETED FORM TO THE APPLICANT