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 Behavior Analyst
- ☐ 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 exam 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

ALL ROLES:

E. Does your state issue an educational certificate for serving in the role in K–12 schools? ☐ YES ☐ NO

i. **If yes,** does your state have a process in place for review and approval of programs for serving in the role in K-12 schools in your state? ☐ YES ☐ NO

ii. **If yes,** does the program the applicant completed have state approval in your state for serving in the role in K-12 schools in your state? ☐ YES ☐ NO

iii. **If yes,** is the state approval for purposes of clinical licensure (i.e. Department of Health) and/or K-12 certification (i.e. Department of Education) for serving in the role? Check any/all that apply:

☐ CLINICAL LICENSURE ☐ K-12 CERTIFICATION ☐ N/A

F. Was the applicant eligible to serve in the specialized role in the common schools in your state when they completed the program? ☐ YES ☐ NO If no, what were the deficiencies? _____

G. What type of state certification was this applicant eligible to receive upon completing your program?

_____

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