



VERIFICATION OF EDUCATION

This form must be submitted directly to the office by the school.

Applicant

Profession Applying for		Date of Birth	
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First Name	MI	Last Name	Former/Maiden

I hereby authorize the License Agency to furnish to the Vermont Office of Professional Regulation the information requested below.

Signature _____ Date _____

To Be Completed by the Authorized Officer

Name of Applicant	
Name of School	
Degree Earned	
Number of hours completed	
Graduation Date	
Mailing Address	P.O. Box
	Street/Apt #
	City/State/Zip
	Country

Signature of Registrar		Printed Name	
Date		Email	

<p>Mail to:</p> <p>Vermont Secretary of State Office of Professional Regulation 89 Main Street, 3rd Floor Montpelier, VT 05620-3402 Attn: (Profession Specific)</p>	<p>(OFFICIAL SEAL)</p>
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