(12/2014)

VERIFICATION OF EDUCATION – Form 2

SECTION 1 – TO BE COMPLETED BY APPLICANT

NAME:	Last	First	Middle

NAME OF COLLEGE/UNIVERSITY:	

ADDRESS:	City	State	ZIP

Request that the college/university submit an official transcript and that the transcript be sent directly to the board in an official school envelope from the college/university or their authorized agent.

SECTION 2 – TO BE COMPLETED BY THE UNIVERSITY'S AUTHORIZED AGENT

NAME OF DEGREE PROGRAM:			
MAJOR COURSE OF STUDY:	☐ Behavioral Analysis	☐ Special Education	☐ Speech Therapy
☐ Psychology: (School; Clinical; Counseling or Developmental)	☐ Professional Counseling	☐ Social Work	☐ Occupational Therapy
☐ Nursing Specialty_____	☐ Another Related Field (List Specific Field): _____ *If this box is checked, the university agent must sign below and complete and submit Form 6.*		

NAME OF STUDENT:	Last	First	Middle

DATE STUDENT BEGAN TO ATTEND THIS PROGRAM:	Month	Day	Year	DATE OF GRADUATION:	Month	Day	Year

CHOOSE ONLY ONE OPTION BELOW

Option 1 ☐ **I CERTIFY THAT THE APPLICANT COMPLTED A MASTER'S DEGREE OR POST MASTER'S CERTIFICATE PROGRAM IN THE AREA INDICATED ABOVE WHICH INCLUDED ALL 90 HOURS OF EVIDENCE-BASED COURSEWORK LISTED BELOW:**

- **3 HOURS OF PROFESSIONAL ETHICS**
- **16 HOURS OF ASSESSMENT COURSEWORK OR TRAINING**
- **8 HOURS OF CRISIS INTERVENTION**
- **5 HOURS OF FAMILY COLLABORATION**
- **18 HOURS OF AUTISM-SPECIFIC COURSEWORK/TRAINING**
- **16 HOURS OF INSTRUCTIONAL STRATEGIES & BEST PRACTICES**
- **8 HOURS OF CO-MORBIDITY & MEDICATIONS**
- **16 HOURS OF ADDRESSING SPECIFIC SKILL DEFICITS TRAINING**

This coursework may be in-person instruction-led or online distance education and does not need to be autism-specific—unless noted.

Option 2 ☐ **I CERTIFY THAT THE APPLICANT COMPLETED A MASTER'S DEGREE OR POST MASTER'S CERTIFCATE PROGRAM IN THE AREA INDICATED ABOVE.** ***The program included some, but not all, of the 90 hours of evidence-based coursework in the content areas listed above.***

IF THIS BOX IS CHECKED, A UNIVERSITY AGENT SHOULD ALSO COMPLETE AND SUBMIT FORM 5 (VERIFICATION OF EVIDENCE-BASED COURSEWORK) TO DOCUMENT THOSE COURSES/HOURS THAT WERE FULFILLED THROUGH THE GRADUATE PROGRAM.

Option 3 ☐ **I CERTIFY THAT THE APPLICANT COMPLETED A MASTER'S DEGREE OR POST MASTER'S DEGREE CERTIFICATE PROGRAM IN THE AREA INDICATED ABOVE.** ***However, the program did not include any of the 90 hours of evidence-based coursework in the content areas listed above.***

SIGNATURE OF UNIVERSITY AGENT:			
DATE:	Month	Day	Year

Seal of college/university
(If the college/university does not have a seal, please submit a letter signed by the university agent attesting to that.)

Upon completion, the school must return the form(s) and transcripts directly to the Pennsylvania State Board of Medicine in an official school envelope.

DO NOT RETURN THE ORIGINAL FORM TO THE APPLICANT

(A COPY of this form can be provided to the applicant upon request.)

Regular Mailing Address
STATE BOARD OF MEDICINE
P.O. BOX 2649
HARRISBURG, PA 17105-2649
717-783-1400/717-787-2381

Courier Delivery Address
STATE BOARD OF MEDICINE
2601 NORTH THIRD STREET
HARRISBURG, PA 17110