

ILLINOIS DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF ENVIRONMENTAL HEALTH  
525 W. JEFFERSON ST.  
SPRINGFIELD, IL 62761

APPLICATION FOR CERTIFICATION AS A STRUCTURAL PEST CONTROL TECHNICIAN  
RESTRICTED-USE PESTICIDES

The application for examination as a certified technician to use or oversee the use of restricted pesticides must be submitted to the above address accompanied by the **\$75** examination fee (\$50 if adding subcategories to your current certificate) if applicable. To be accepted for examination, the completed applications and fee must be received by the Department no later than 15 days prior to the examination date. All fees, payable to the Illinois Department of Public Health, shall be in the form of a certified check, money order, or personal check and are **non-refundable** in the event the application is unacceptable.

PRINT OR TYPE ONLY

NAME OF APPLICANT \_\_\_\_\_  
(Last) (First) (Middle)

HOME ADDRESS OF APPLICANT \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

HOME TELEPHONE NUMBER \_\_\_\_\_ / \_\_\_\_\_ COUNTY \_\_\_\_\_  
(area code)

AGE OF APPLICANT \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SOC. SEC. # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

HIGH SCHOOL GRADUATE \_\_\_\_\_ Year \_\_\_\_\_ or GED CERTIFICATE \_\_\_\_\_ Year \_\_\_\_\_

NAME/ADDRESS OF SCHOOL \_\_\_\_\_

(Verification may be requested by IDPH)

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**EDUCATION \*** (Complete if eligibility is based upon college course work or IDPH approved pest control course)

<u>COLLEGE</u>	<u>COURSE HOURS FOR ENTOMOLOGY RELATED FIELDS</u>		
<u>YEAR</u>	<u>NAME OF INSTITUTION</u>	<u>QUARTER</u>	<u>SEMESTER</u>
_____	_____	_____	_____
_____	_____	_____	_____

**PEST CONTROL COURSE\***

<u>TITLE OF COURSE</u>	<u>NAME/ADDRESS OF SPONSOR</u>	<u>DATE COMPLETED</u>
_____	_____	_____
_____	_____	_____

**\* Attach College Transcript or Pest Control Course Completion Certificate to the Application**

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EMPLOYER (Business Name) \_\_\_\_\_

PEST CONTROL BUSINESS I. D. NUMBER (051 or 053, if applicable) \_\_\_\_\_

BUSINESS ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

BUSINESS TELEPHONE NUMBER \_\_\_\_\_ / \_\_\_\_\_ COUNTY \_\_\_\_\_  
(area code)

LIST EXPERIENCE IN PEST CONTROL FIELD --- ATTACH ADDITIONAL SHEET IF NECESSARY

From (date)	To (date)	Employer	Business Address	Supervisor
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

\*\*\* **COMPLETE REVERSE SIDE** \*\*\*

**IMPORTANT NOTICE** - THIS STATE AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED UNDER PUBLIC ACT 79-578. DISCLOSURE OF THIS INFORMATION IS MANDATORY. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

