**Date Submitted: \_\_\_\_\_\_\_\_\_\_**

**Initials of Receiver: \_\_\_\_\_\_**

**Department of Special Education**

**Application for Departmental Approval to Student Teach**

**NOTE:** Students will be Considered at the Mid-Point of the Semester, Just Prior to Student Teaching, If All Specified Criteria are Met.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last First MI

Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Advisor:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A. Participation in Professional Organization

Name of Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. Special Education Option and Primary Area of Emphasis (Area in Which You Plan to Student Teach is the Primary Area.)

1. Option:

🞎 Early Childhood **Or** 🞎 Standard Special

1. Dual Certification:

🞎 Elementary **Or** 🞎 Secondary **Or** 🞎 Early Childhood

1. Primary area of Emphasis:

🞎 LBS I

1. Semester You Plan to Student Teach: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D. Attach Proof of Current CPR Certification, Unless Previously Submitted to the Department.