METROPOLITAN STATE UNIVERSITY OF DENVER

Office of Clinical Experiences and Partnerships

Verification of Supervision of Resident

EDUCATOR INFORMATION:

Educator Name: ____

Street Address: ____

City: __________________________________ State: __________ Zip: __________________

DESCRIPTION OF RESIDENCY EXPERIENCE:

Name of Resident: ____

Inclusive Dates of Residency: From: ______________________ To: ______________________

Host School/District: _________________________________ Semester/Year-Semester/Year: _______________

SCHOOL DISTRICT VERIFICATION:

SIGNATURE:

Principal or designee: ____Date: ____________________

OFFICE USE ONLY

VERIFICATION OF RENEWAL CREDIT:

This is to verify that the licensed individual named herein has successfully supervised a resident and is recommended for _____ semester hour(s) of professional development renewal credit.

__________ 67.5 clock hours (4.5 semester hours) for sole supervision of a yearlong resident

__________ 33.75 clock hours (2.25 semester hours) for shared supervision of a yearlong resident or one semester

SIGNATURE:

Director, Clinical Experiences and Partnerships: ____

Dr. Megan Lawless