

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. Bryan Bohanan