METROPOLITAN STATE UNIVERSITY OF DENVER

Office of Clinical Experiences and Partnerships

Verification of Supervision of Student Teacher

EDUCATOR INFORMATION:

Educator Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

DESCRIPTION OF STUDENT TEACHER EXPERIENCE:

Name of Student Teacher: _____

Inclusive Dates of Student Teaching: From: _____ To: _____

Host School/District: _____ 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 student teacher and is recommended for _____ semester hour(s) of professional development renewal credit.

_____ 45 clock hours (3 semester hours) for sole supervision of a 16 week placement

_____ 22.5 clock hours (1.5 semester hours) for supervision of an 8 week or shared placement

SIGNATURE:

Director, Clinical Experiences and Partnerships: _____

Dr. Megan Lawless