**SCHOOL IMAP APPROVAL FORM**

**School Corporation/School Name**

**Address**

**City, State**

**Phone #**

**The following educators have completed 2nd year IMAP requirements and   
are eligible for a 5 year Practitioner’s license.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **FIRST Name** | **LAST Name** | **Role within School** | **School** | **Complete** |  |
| *Sally* | *Smith* | *Teacher* | *Red Brick Elementary* | *X* |  |
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