INDIANA DEPARTMENT of EDUCATION

Verification of Practicum Experience Form

Required: Please check all that apply to your 10-week practicum experience for this evaluation:

☐Job Shadowing
☐Field Experiences
☐Teaching Cooperatives
☐Full-term student teaching
☐One year full-time secondary teaching in the content area being licensed.

Last Name: _____ First Name: _____ MI: ___ Former Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Birthdate: _____

The following information must be completed by Supervisor/Human Resources/Payroll Personnel
(Current school may verify previous employment)

Name of School/College/University: _____

Address: _____ City: _____ State: _____ Zip: _____

Beginning Date of Service (mm/dd/yyyy)	Ending date of Service (mm/dd/yyyy)	Total Years of Service	Position Held/ Grade/ Subject

I hereby certify that the above listed experience is a true and correct for the educator named above.
(This form must be signed by an authorized official from the agency/institution as stated above.)

Signature: _____ Title: _____ Phone Number: _____

Email Address: _____ Date: _____