UNT | DALLAS
School of Education

Administrator Verification Form

Co-Operating Teacher Name_______________ Date ______________________

Clinical Teacher ________________________ Semester____________________

1. The Cooperating Teacher listed has at least three (3) years of teaching experience: (if NO. please document reason for selecting this cooperating teacher.)

______YES ________ NO

2. The Cooperating Teacher currently holds certification in the same category as the Clinical Teacher. (if NO: Please document the reason for selecting this cooperating teacher.

______YES _______NO

3. The Cooperating Teacher is an accomplished educator as shown by student learning.

_____YES ______ NO

4. Evidence this Cooperating Teacher is accomplished as an educator. (Note: Special district criteria)

***If the Cooperating Teacher listed above does not meet the listed requirements, please document the reason for selecting this individual as a Cooperating Teacher.

Acknowledgement

I attest that the information provided above is accurate to the best of my knowledge.

____________________________________ ____________________________________

Printed Name Signature and Date