

Student Teaching Application Checklist

Please make sure **YOU MEET** the following criteria and attach the following documents
PRIOR TO SUBMITTING this Application for Student Teaching:

Name: _____
Status: Undergraduate Licensure-Only Lateral Entry 2nd Degree
Are you a TA? No Yes **Are you a Lateral Entry Teacher?** No Yes
School/System (if TA or Lateral) _____
Email Address _____ **Phone** _____
Permanent Advisor _____ **Licensure Area** _____

- Upon reaching the Student Teaching Block, I will have successfully completed **All coursework** except the 12 hours of the block, and will have met **all required minimum grades.**
- I will have at least 124 “earned hours” upon completion of the Student Teaching Block.
(This applies to degree-seeking students only.)
- I understand that I will not be allowed to student teach if I do not pass the criminal background check.

DOCUMENTS ATTACHED TO THIS APPLICATION

- Completed Triangle Alliance Application for Student Teacher (including full SSN)
- Completed Triangle Alliance Student Information Form
- Current Resume
- A copy of your TEP acceptance card or letter (You must be admitted 1 semester prior to student teaching.)
- A current printout of your Banner Transcript (Print this on your own. Your GPA must be at least 2.5)
- An updated copy of your program of study (Get this from your advisor.)

Health Exam and TB test - **DO NOT** see your physician until:

After May 7 for Spring applicants

After December 10 for Fall applicants

- Completed NC Public Schools Student Teaching Health Examination Certificate, signed and dated by your physician
- Current TB Test with results, signed and dated by your physician

Please note that these documents must **not be signed** by your physician **before** the dates listed above.

Please read and sign below:

I understand that submission of an application does not guarantee that I will be able to participate in student teaching in the semester I am requesting. I understand that my application will be reviewed and my placement may be postponed until all conditions and requirements are met.

I also understand that any requests made for particular schools or cooperating teachers are not guaranteed. When extenuating circumstances occur, placements will be made based on the consensus among the University-School Partnerships Director, the Department Chair, and the Program Coordinators.

Signature _____ **Date** _____

INSTITUTION OF HIGHER LEARNING	ASSIGNMENT REQUEST <i>(IHE complete in pencil)</i>	ASSIGNMENT REQUEST <i>(IHE complete in pencil)</i>
	1. Cooperating Teacher/Supervisor: _____	2. Cooperating Teacher/Supervisor: _____
PARTICIPATING AGENCY	1. Subject and/or Grade: _____	2. Subject and/or Grade: _____
	1. School: _____	2. School: _____
	Confirmed: _____	Confirmed: _____

TRIANGLE ALLIANCE

APPLICATION FOR STUDENT TEACHER OR INTERN

(circle one)

PLEASE TYPE OR PRINT

Name _____
Mr./Mrs./Miss/Ms. Last First Middle Maiden Prefer to be called

SSN# _____ Date of Birth _____ Race _____
Mo Day Yr (Optional)

ADDRESS INFORMATION

2008 - 2009 Local Address _____ Phone _____
Dates effective: _____ through _____

2007-2008 Local Address _____ Phone _____
Dates effective: _____ through _____

Permanent/Home _____ Phone _____

LICENSURE INFORMATION

Area and/or Level(s) of licensure desired (*e.g.*, Elementary [K-6], Secondary Science [9-12]): _____

Anticipated graduation date: _____

Expected degree: ___ Bachelor's ___ Master's ___ Doctorate ___ Licensure-Only

STUDENT TEACHING/GRADUATE INTERNSHIP

Spring 2009 _____ (part time) or (full time)
 Summer 2009 _____ (part time) or (full time)
 Fall 2009 _____ (part time) or (full time)

Dates of Full Time Assignment: From _____ to _____
 First day to report for observation: _____

PLEASE NOTE

Subject(s) and/or grade(s) preferred (*List 2-3 in order of preference*)

1. _____ 2. _____ 3. _____

EDUCATION

(Provide School Name, City/County, State)

Undergraduate (if graduate student): _____

High School: _____

Middle/Junior High: _____

Elementary: _____

EMERGENCY CONTACTS

<i>Name</i>	<i>Relationship</i>	<i>Day Phone</i>	<i>Evening Phone</i>

<i>Name</i>	<i>Relationship</i>	<i>Day Phone</i>	<i>Evening Phone</i>

HEALTH *(Health Form must be completed and submitted.)*

Condition: _____ Have you been under a doctor’s care during the past two years?

___ Yes ___ No If “YES,” explain briefly. _____

TRANSPORTATION PROBLEMS? ___ Yes ___ No If “YES,” explain briefly. _____

1. Student teachers/interns are expected to abide by the participating agency’s calendar and by all the schedules and policies in effect in the school to which they are assigned.
2. Student teachers/interns will receive no financial remuneration for the student teaching/intern experience.
3. Student teachers/interns will be assigned to schools without regard to the sex or race of the applicant.

Signature of Student Teacher/Graduate Intern _____ *Date*

RECOMMENDATION OF INSTITUTIONAL REPRESENTATIVE

Signature of Institution of Higher Education Representative _____ *Date*

This application will be forwarded to participating school districts by the institution of higher learning contact person.

North Carolina Public Schools

Student Teaching/Graduate Internship Health Examination Certificate

Required of all persons upon initial employment, or separation from employment more than one school year, or deemed necessary by a local school board or superintendent. This certificate must be completed and signed by a physician licensed to practice medicine in the State of North Carolina (NCGS §115C-323). For student teaching purposes, this information may be provided by an out-of-state physician.

Name _____
 Social Security Number _____ Subject Area _____
 Address _____
 Telephone: _____

The above named individual is to be recommended for employment by _____ (local school board) in a position of student teacher/graduate intern. In this position, the condition of certain physical capacities will be of importance. Please examine the areas listed below and report any limitations, deficiencies or related restrictions.

AREAS	LIMITATIONS		NATURE OF LIMITATIONS
	YES	NO	
Vision			
Hearing			
Heart			
Lungs			
Lifting/Carrying			
Other			

TB Test Information

Result (*circle one*): **POSITIVE** **NEGATIVE**

Test Date: _____

Name of person administering TB test (*please type/print*)

Telephone Number

Signature _____

By my signature I certify that the above named person does not have any communicable disease, including tuberculosis, that poses a significant risk of transmission in our schools or would impair this person's ability to perform the duties of the job, except as may be noted above. Further I certify that this person is free of any physical or mental disability that would impair job performance.

If unable to certify, please comment:

Date _____

Physician name (*please type/print*)

Telephone Number

Physician's Signature _____ **M.D.**

