Student Teaching Application Checklist

REQUIREMENTS MUST BE MET BEFORE SUBMITTING YOUR STUDENT TEACHING APPLICATION

[ ] Upon reaching the student teaching block, I will have successfully completed:

- **all coursework** except the 12 hours of the block.
- **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.

Last Name: _____ **First Name:** _____ **Middle**:_____

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) _____

Desired System for Placement _____

NCCU Email Address _____ **Phone** _____

Permanent Advisor _____ **Licensure Area** _____

STUDENT TEACHING APPLICATION PACKET

(YOU MUST SUBMIT A COMPLETE PACKET)

IMPORTANT: Applications submitted after deadline will not be accepted.

[ ] Completed Triangle Alliance Application for Student Teachers/Interns (include full SSN)
[ ] Completed Triangle Alliance Student Information Form
[ ] Current resume
[ ] A copy of your TEP acceptance card or letter (you must be admitted at least one semester prior to student teaching.)
[ ] A current printout of your Banner transcript showing a 2.5 grade point average or higher
[ ] An updated copy of your program of study (you must get this from your advisor if you do not have a copy)
[ ] Completed North Carolina Public Schools Student Teaching Health Examination Certificate signed and dated by a physician/health provider
[ ] Current TB test with results, signed and dated by your physician

NOTE: Health exams and TB tests are good for 1 year only and must be current through the internship.

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 (*IHE complete in pencil*)	ASSIGNMENT REQUEST (*IHE complete in pencil*)
PARTICIPATING AGENCY	1. Cooperating Teacher/Supervisor: _____ 1. Subject and/or Grade: _____ 1. School: _____ Confirmed:	2. Cooperating Teacher/Supervisor: _____ 2. Subject and/or Grade: _____ 2. School: _____ 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

2010 - 2011 Local Mailing Address_____ Phone_____

_____*Dates effective:*_____ *through*_____

2009-2010 Local Mailing Address_____ Phone_____

_____*Dates effective:*_____ *through*_____

Permanent/Home Mailing Address_____ 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 SEMESTER/YEAR

Fall (year) _____

Spring (year) _____

Dates of Full Time Assignment: From _____ to _____

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

_____

Name *Relationship* *Day Phone* *Evening Phone*

_____

Name *Relationship* *Day Phone* *Evening Phone*

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.

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

TRIANGLE ALLIANCE

STUDENT INFORMATION FORM

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

Current Address:_____ Phone_____

_____*Dates effective:*_____ *through*_____

Permanent Address_____ Phone_____

_____*Dates effective:*_____ *through*_____

What is/are your major(s)? (1)_____(2)_____
Subject Area Concentration?_____
Expected degree:____Bachelor's ___Master's ____Doctorate ____ Licensure-Only

Comments to be handwritten by the applicant using a pen with black ink.
All responses <u>must</u> be recorded in the space provided
This information will be forwarded to your cooperating teacher.

1. What strengths and experiences do you bring to student teaching? (Include information about curricular and extra-curricular activities that may relate to placement, any outstanding activities or achievements, and prior work with groups of children.)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

2. Please provide a brief autobiographical statement.

3. As you think about your student teaching/internship, what are you most excited about?

Signature of Student Teacher/Graduate Intern *Date*

Institution

Revised 11/08

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, which 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.**