

UNIVERSITY/COLLEGE PROGRAM VERIFICATION

To ISD: _____, Supt.

From: _____
University/College Code #: _____
Office of Special Ed. & Early Intervention Svcs.
Candidate Name: _____

Requested By: _____
School District: _____
Address: _____

This candidate is enrolled in the following training program:

- | | |
|--|--|
| <input type="checkbox"/> Emotional Impairment | <input type="checkbox"/> Physical Impairment & Other Health Impairment |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Physical Education for the Handicapped |
| <input type="checkbox"/> Cognitive Impairment | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Director |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Supervisor |
| <input type="checkbox"/> Early Childhood (for candidates pursuing Early Childhood Special Education) | |

This request applies to the school year 20____ - 20_____.

For continuing temporary approval only:

I verify that the candidate has completed _____ semester hours toward full approval or endorsement between September 1 and August 31 of the previous school year.

If this candidate did not complete the required 6 semester hours for continuing approval, was additional coursework available? Yes No

Evaluator: _____ Date: _____