

FULL APPROVAL FOR TEACHER CONSULTANT REQUEST FORM

Note: Documentation that supports the following statements must be maintained in this candidate's file for audit purposes. The employing school district and intermediate school district retains all responsibilities related to the accuracy of this request.

Candidate's Last Name _____ First Name _____ MI _____

ISD Name: _____ LEA Name: _____

Program Category: _____ University/College: _____

Effective Date: Month _____ Date _____ Year _____

YES NO

- _____ _____ 1. This candidate holds a valid Michigan teaching certificate showing a special education endorsement in the category in which this teacher consultant approval is requested. The special education endorsement must be in one of the following areas: autistic impaired, mentally impaired, emotionally impaired, learning disabled, hearing impaired, visually impaired, and physically and otherwise health impaired. (attach copy)
- _____ _____ 2. This candidate has earned a master's degree in education or a field of study related to special education. (attach copy)
- _____ _____ 3. This candidate has completed a minimum of three years of satisfactory teaching experience, not less than two years of which shall be in teaching students with disabilities in a special education classroom. (attach copy)
- _____ _____ 4. Personnel signatures by the employer and ISD.

PERSONNEL SIGNATURES:

LEA/Employer Signature

Date

ISD Superintendent/Designee Signature

Date

Return to: _____

cc: Intermediate School District

(ISD Contact) _____

School District

Candidate

Telephone #: _____

University/College (if applicable)

Email: _____