Illinois State University
Teacher Education Clinical Experience
Student Self-Placement Form

Please Print Clearly

Student Name_____ **UID**_____-_____-_____ **Semester/Year**_____
(Please Print)

ISU Course for Which Clinical Experience is Occurring

_____
Department Course Number Section Number Instructor Name

School/Agency/Site Information

_____
School/Agency/Site Name Address City Zip Code Telephone Number

Administrator Information

_____
Name Title

____ Yes, this student is allowed to complete _____ clinical experience hours for above named course.
(number of)

_____
Administrator Signature Date

Observation Date	**Teacher Name** (Print)	**Teacher Signature**	**Teacher DL# or Birthdate**

**Driver's license number and/or birthdate is necessary for the processing of student documentation forms and to assure tuition waivers for school districts

Cecilia J. Lauby Teacher Education Center
56 DeGarmo Hall Campus Box 5440
Normal, IL 61790-5440
Adrian Lyde, Coordinator , Pre-Student Teaching Clinical Experiences
(p) 309/438-5416 (f)309/438-8684

Please return this form to your ISU instructor. The instructor will then return this form to the Teacher Education Center in DeGarmo 56.