

NORFOLK STATE UNIVERSITY
School of Education
Office of Clinical Experiences and Student Services

<i>For Office Use Only</i>
Major: _____
No. of Hours Required: 1 st _____ 2 nd _____
Placement Division (s): _____
1 st exp _____ 2 nd exp _____
Dir: _____ Clerk: _____
Date _____

Application for Graduate Internship

(*SEMESTER: When do you plan to begin the Internship?)

Major: _____	*Semester: _____	*Year: _____			
Applicant's Name: (Please Type)	Last	First	MI	Student ID	

CERTIFICATION INSTRUCTIONS:

This certification/departmental endorsement is to be completed by the applicant, official representative(s) of the School of Education, and the department from which the applicant is a major. All applications will be maintained by the Office of Clinical Experiences and Student Services (OCESS). Make copies of documents before submitting them to the OCESS. Personal copies of documents are the responsibility of the applicant. PLEASE type responses in blanks where required. No candidate is allowed to make their own final individual placement arrangements.

APPLICANT CERTIFICATION:

I further understand that failure to comply with the agency or field placement guidelines or substandard performance in the Internship experience may result in dismissal from the Internship program.

I fully understand that proof of successful completion of the VCLA, VRA, PRAXIS Core, or SLLA, if applicable, required certificates, School Division's Placement Request form, the background verification form, tuberculosis/chest x-ray and other required documents are integral to this application process and I will comply as requested. See the application guidelines for counseling.

I certify that all information given is correct, and that I have completed all program requirements for admission to the clinical experience. I will be eligible to begin the Internship in the upcoming semester.

 Applicant's Signature (Date)

DEPARTMENT ENDORSEMENT

On the basis of my knowledge of the applicant's preparation and characteristic performance in the subject matter area of _____, I ___ DO ___ *DO NOT endorse this applicant as a worthy and promising candidate for the Practicum during the upcoming semester.

Department Head , please indicate the University Supervisor:		Course number(s)

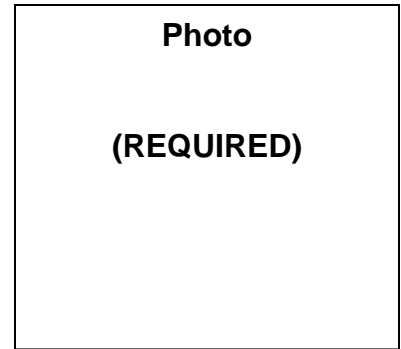
Signed by (Advisor):	Date:
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Approved by (Major Head of Department):	Date:
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*Comment(s)

[Type text]

NORFOLK STATE UNIVERSITY
School of Education
Office of Clinical Experiences and Student Services



Application for Graduate INTERNSHIP, p.2

Please check applicable program:

MA DEGREE	<input type="checkbox"/>	CERTIFICATION ONLY	<input type="checkbox"/>	Pre-ECE	<input type="checkbox"/>
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SECTION I--Personal Data					
Date of Birth: (MM/DD/YY)		Gender		Ethnicity	
Applicant's Name: (Please Type)	Last		First		Middle
					Student ID
Address: (Local)	Street		City		State
					Zip Code
Telephone: (Local)	(Home)	(Work)	(Cellular)	Email	
Address: (Permanent)	Street		City		State
					Zip Code
Telephone: (Permanent)	(Home)	(Work)	(Cellular)	Email	
Emergency Contact:			(Relationship)	(Phone)	
(Local-other than where you reside)					

SECTION II - - Education History						
Name of College attended other than NSU:						
Degree Received (BA, BS etc., and DISCIPLINE)				Graduation Date:		
~Norfolk State University Information~						
Advisor:						
Major:		Emphasis:			Graduation Date:	
Special Education:	General Curriculum	<input type="checkbox"/>	Adapted	<input type="checkbox"/>	<input type="checkbox"/>	(PRACTICUM)
Date Admitted to Teacher Education: (MM/DD/YY):						
PRAXIS core Test Score:		SLLA Test score:				

SECTION III - - Teaching Related Experience (other than ECSE)				
Teacher Assistant	<input type="checkbox"/>	School		How many years?
Substitute Teacher	<input type="checkbox"/>	School		How many years?

SECTION IV - - Teaching Status					
Do you have at least one year experience as a contracted teacher?				*YES <input type="checkbox"/>	NO <input type="checkbox"/>
If "YES", complete this row for all experiences.	School Name:		City:	Beginning Year?	

Norfolk State University School of Education
 Department of Secondary Education and School Leadership

***Required for Administration and Supervision Programs Only**

APPLICATION MATRIX

Fill – in UED 793 and UED 794 on the row of the level you are requesting.

380–Hour (Course Embedded & Cumulative) Internship Experience Required by Program						
Verify the Internship Experiences completed previously with the Instructor’s signature. Hours as listed are to be distributed among the five levels listed and ensure that diverse settings among urban and non urban environments as well as diverse and less diverse environments are included. Complete the chart below with the appropriate information (<u>level, hours, & courses as you completed them</u>) selected from the choices in each column.						
Hours: Indicate total number of hours completed at each level. <u>Place UED793 and 794 and the no. of hours you are requesting next to the appropriate level.</u>						
Courses: indicate either UED 617, UED 630, UED 671, UED 783, UED 793, UED794, or other courses						
Indicate Urban or Non-urban type setting for location of the venue.						
Indicate Diverse or Less-diverse environment for the field experience.						
Levels and required settings:	Hours total = 200	Course(s)	Urban/Non-urban (at least two settings each)	Diverse/Less-diverse (ethnic/socio economic/ academic)(at least two environments each)	Instructor’s signature to verify hours completed:	
Elementary School						
Middle School						
High School						
Either level above or other level						
Central Office- indicate the dept. requested: _____	80	UED 793				
Agency						

Candidate’s Name _____ signature _____ Date _____

Advisor’s Name _____ signature _____ Date _____

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Application for Internship continued

SECTION IV - - Describe your philosophy of education leadership/teaching.

SECTION V -- Placement Request Information (COMPLETE EACH BLOCK IN THIS SECTION)

*** Note - In order to meet the diversity requirement for experiences, you may select two different school divisions for your placements.**

* School Division:	(1st Experience)		(2nd Experience)	
Grade level/subjects requested			Grade level/subjects	
No. of hours you will intern per week			No. of hours per week	
		No. of hours requested		No. of hours requested
<u>Department Head/designee's signature</u> to indicate approval of selected clinical practice locations, levels, & hours.				
** Do you have a need for any special requests?			If YES, attach a letter or explanation supporting the request.	

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Application Placement Request - Initial Contact Information

Complete this form if your request is for a school division other than one of the seven Hampton Roads cities or for an Agency.

Intern candidate should make an initial contact to determine if the school division, administrator, or agency will allow the internship.

“The educator as a competent, cooperative, compassionate, and committed leader.”

Applicant's Name: (Pease Type)				
	Last Name	First Name	Middle	

Address:				
	Street	City	State	Zip Code

Telephone			
	(Home)	(Cellular)	Email

This is to confirm that _____ <p style="text-align: center;">Intern's Name</p> Will be permitted to complete his/her Graduate Internship at _____			
(Name of Site)		Site Telephone #	
(Street)	(City)	State	(Zip Code)
Person to contact: _____		email: _____	
To satisfy requirements (____ CLOCK HOURS) for the Graduate Intern Program. _____ <p style="text-align: center;">Director or Principal of Practicum Site</p> _____ <p style="text-align: center;">Mentor/Advisor's Signature</p> _____ <p style="text-align: center;">University Supervisor's Signature</p> _____ <p style="text-align: center;">Date</p>			

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Application - Tuberculosis Test

Last Name _____	First Name _____	MI _____
SSN _____	Age _____	DOB (MM/DD/YY) _____
<input type="checkbox"/> Male	<input type="checkbox"/> Female	Race _____
Street Address, City, State & Zip _____		
Telephone: <i>Home:</i> _____ <i>Work:</i> _____		
<i>Cellular Phone:</i> _____ email: _____		

Requested for (please check one) Fall _____ Spring _____ Year _____
On the basis of chest X-ray, test, and/or examinations, I hereby certify that the student identified at the top of this page is diagnosed to be free of communicable tuberculosis as of the date below.
I am a licensed physician in _____ (State or District), United States of America
Date: _____ Signed: _____
Address: _____
Telephone: ____ (____) _____
Virginia State Law requires the education candidate to return this TB Certification to the Office of Clinical Experiences and Student Services prior to the field experience. The test is to be effective through the entire field experience.

Norfolk State University
School Education
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Application - Background Verification Form

Background Verification Form

Addendum to Field Experience and Clinical Practice Applications

All applicants are required to read and verify the following statements when submitting requests for field placements:

I have not been convicted of a violation of law other than a minor traffic violation.
I do not have any criminal charges or proceedings pending against me.
I do not have a felony, misdemeanor, or other offense for drugs, sexual abuse, and/or child abuse.
I understand that if the above mentioned conditions are violated, it can result in cancellation of the field experience.

If you are able to verify the above statements when submitting requests for field placements, please sign below:

Print Name	Signature	Date

If you are unable to verify one or more of the above statements, please give a brief explanation below and schedule a conference with the Director, OCESS. Please sign below the box:

Student Comments:

Print Name	Signature	Date