



**Approved Program Verification Form**

For Special Service Licensure Only

**Applicant:** Complete the top (blue) portion of this form in its entirety; forward it to your college/university for completion of the remainder (green section); upload the completed form to your application.

**To be completed by the Applicant**

\* Required Field by Applicant

Last Name*		First Name*		Middle Name	Date of Birth*
List any Previous Names Used*			Contact Daytime Phone*		Email Address*
<input type="checkbox"/> None					
Mailing Street Address*			City*	State*	Zip*
Social Security Number* (last 4)	X X X - X X -	College/University ID Number (leave blank if none or if unknown)			

**To be completed by the Designated Representative of the Approved Preparation Program**

<b>1</b>	The individual successfully completed an approved preparation program on:	Date
<b>2</b>	The individual was prepared in the field of:	Examples: Audiology, Occupational Therapy, Nursing, School Psychology, Social Work, Speech-Language Pathology, etc.)
<b>3</b>	Was the individual's Practicum/Internship/Clinical completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hours of Practicum/Clinical:
	Hours of Internship:	Setting of Practicum/Internship/Clinical: Examples: School, Community/Public Health, etc.
<b>4</b>	<b>For School Social Work ONLY:</b>	
	<b>a</b> Did the individual complete coursework in school/special education law (IDEA, 504 and ADA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<b>b</b> Did the individual complete coursework that included FBA (Functional Behavior Assessment) and BIP (Behavior Intervention Plans)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>5</b>	Do you know of any reason the individual should not serve in Colorado schools? <small>*If "yes," please send a brief statement of explanation to the Director of Educator Licensure via the address above.</small>	<input type="checkbox"/> Yes* <input type="checkbox"/> No
<b>6</b>	Was the individual eligible to hold a standard license/certificate in your state at the time of program completion? <small>**If "no," please identify any remaining requirements</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No**
<b>7</b>	Do you verify that the individual named above has successfully completed a state-approved program in the field/specialty indicated; that the individual is in good standing; and that the individual has the knowledge and competencies essential for educational service? <small>**If "no," please identify any remaining requirements</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No**

College/University Name				
Street Address	City	State	Zip	Phone Number
Name (printed or typed)	Title	Date		
Signature	Contact email address			