THE UNIVERSITY IS RESPONSIBLE FOR COMPLETION AND SUBMISSION OF THIS APPLICATION

ARKANSAS DEPARTMENT OF EDUCATION
STANDARD LICENSE APPLICATION

CURRICULUM/PROGRAM ADMINISTRATOR

Name: _____ S.S.# _____

Mailing Address: _____

City, State, Zip: _____ E-mail: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Specify One Specialty Core Area: □ **Special Education** □ **Gifted & Talented** □ **Career & Tech Education** □ **Adult Education** □ **Curriculum** □ **Content Area Specialist (Specify content area:_____)**

Institution of Higher Education:

This applicant has successfully completed the following requirements for a Curriculum/Program Administrator License: (Check [✓] all applicable items.)

- ❑ **Graduate Degree or** □ **Program of Study** (based on the *Current Leadership Standards for Licensure of Beginning Administrators*)
- ❑ **Internship**
- ❑ **Has a minimum of 3 years licensed experience in one of relevant areas above**: (verification enclosed)
- ❑ **Successfully passed the School Leaders Licensure Assessment.**

Check the Level of license requested.

□ **P-12**

_____ _____
(Educational Leadership Program Chairperson Signature) (Date of Degree/Program Completion)

_____ _____
(University) (Licensure Officer Signature) (Date)

Applicant:

I have been informed of the requirements for an Arkansas Curriculum Program Administrator License. **It is my responsibility to submit the following required documentation to the University in order to be recommended for this license.**

□ **A current Arkansas Standard Teaching License.**
❑ **Documentation of at Least 3 years licensed experience in one of relevant areas above:**
❑ **Official College/University Transcripts reflecting the Master's Degree/Master's level program of study.**
❑ **Passing scores for the School Leaders Licensure Assessment.**
*** Documentation of Experience** may be on school letterhead or an official personnel record verifying employment and specifying the **number of years taught in in the specific content areas. The document must exhibit the Superintendent's (or Designee's) signature.**

* Upon employment as a **Curriculum Program Administrator**, I shall participate in **the Arkansas Beginning Administrator Induction/Mentoring Program. (1-3 years)**

_____ _____
(Applicant Signature) (Date)

AFFIX OFFICIAL INSTITUTION SEAL IN THIS AREA

MAIL COMPLETE ORIGINAL FORM TO :
Arkansas Department of Education
Office of Educator Licensure
Four State Capitol Mall Room 106B
Little Rock, AR 72201

KEEP A COPY FOR YOUR RECORDS

July 2018