

## VERIFICATION OF TEACHING EXPERIENCE

<b>SECTION I: TO BE COMPLETED BY APPLICANT. APPLICANT MUST SEND THIS FORM TO ALL EMPLOYERS TO VERIFY CONTRACTED TEACHING EXPERIENCE.</b>				
SOCIAL SECURITY NUMBER				
CURRENT NAME (LAST, FIRST, MIDDLE)				
ALL MAIDEN/ FORMER NAMES				
STREET ADDRESS				
CITY, STATE, ZIP CODE			EMAIL ADDRESS	
DATE OF BIRTH	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>	PHONE NUMBERS	
I hereby give my former and/ or current employer permission to release any and all information required in Section II				
LEGAL SIGNATURE OF APPLICANT			DATE	
<b>SECTION II: TO BE COMPLETED BY EMPLOYING SCHOOL SYSTEM</b>				
The above named individual was employed as a teacher in our school system as verified below				
<b>SUBJECT/AREA TAUGHT</b>	<b>GRADE LEVEL(S)</b>	<b>BEGINNING DATE</b>	<b>ENDING DATE</b>	<b>TOTAL YEARS AT THIS LEVEL</b>
<b>ADMINISTRATIVE EXPERIENCE:</b>				
<b>POSITION/JOB TITLE</b>	<b>GRADE LEVEL(S) SERVED</b>	<b>BEGINNING DATE</b>	<b>ENDING DATE</b>	<b>TOTAL YEARS AT THIS LEVEL</b>
<b>SUMMATIVE EVALUATION DATE:</b>				
<b>EFFECTIVE TEACHER STATUS:</b>				
	EFFECTIVE <input type="checkbox"/>		HIGHLY EFFECTIVE	<input type="checkbox"/>
NAME OF SCHOOL SYSTEM				
SCHOOL ADDRESS				
CITY, STATE, ZIP CODE				
ADMINISTRATOR'S NAME (PRINT)		ADMINISTRATOR'S POSITION	SCHOOL PHONE NUMBER	
ADMINISTRATOR'S SIGNATURE			DATE	

*This form may be duplicated for additional employers.*

**Please return this form to:**  
**Arkansas Department of Education**  
**Division of Elementary & Secondary Education**  
**Educator Licensure Unit**  
**Four Capitol Mall Room 106B Little Rock, AR. 72201**  
**Fax #: 501-682-4898 OR**  
**Email: ade.educatorlicensure@arkansas.gov**