UNT DALLAS
School of Education

RESET

Administrator Verification Form

Co-Operating Mentor Teacher Name_____ Date _____

Clinical/Student Teacher _____Semester_____

Campus Name_____

1. The Cooperating Teacher listed has at least three (3) years of teaching experience: (if NO. please document reason for selecting this cooperating teacher.)

☐ YES ☐ NO

2. The Cooperating Teacher currently holds certification in the same category as the Clinical Teacher. (if NO: Please document the reason for selecting this cooperating teacher.

☐ YES ☐ NO

3. The Cooperating Teacher is an accomplished educator as shown by student learning.

☐ YES ☐ NO

4. Evidence this Cooperating Teacher is accomplished as an educator. (Note: Awards won, STAAR results, Special district criteria)

***If the Cooperating Teacher listed above does not meet the listed requirements, please document the reason for selecting this individual as a Cooperating Teacher.

Acknowledgement

I attest that the information provided above is accurate to the best of my knowledge.

_____ _____

Principal Printed Name **Signature and Date**

Principal Email address_____

TEA ID of Co-Operating Teacher_____

Updated 8/8/2022