PROVIDENCE COLLEGE
SCHOOL OF CONTINUING EDUCATION

Cooperating Teacher Information

Please fill out this form, scan it, and email it to Dr. Hibbard at khibbar1@providence.edu as an attachment. Alternately, you may fill out the form, print it and mail it to me at the address listed at the bottom of the document.

TCP Student Information

TCP Student's Name _____

Certification Area _____

Clinical Experience (check one)
- ❑ EDU 207/792 Principles of Secondary Education (20 hrs.)
- ❑ EDU 402/813 Educational Measurements (20 hrs.)
- ❑ EDU 410/808 General Methods (20 hrs.)
- ❑ Clinical I (30 hrs.)
- ❑ Clinical II (30 hrs.)

Placement Information

School _____ Grade(s) _____

Town _____ State _____

Cooperating Teacher Information

We ask for your home address so that we can mail a gift card to you at the end of the clinical experience as a small token of our appreciation for your work hosting a Providence College student.

Name _____

Street/PO Box _____

City, State _____ Zip Code _____

Email Address _____

If mailing this form, the address is:

Dr. Kate Hibbard
Providence College
School of Continuing Education
1 Cunningham Square
Providence, RI 029

For TCP use only

Form received _____
Gift card sent _____
Sender's initials _____