

To be returned to: Barbara Owens  
Director of Clinical Experiences  
Room 328 A

## CLINICAL EXPERIENCE PLACEMENT FORM EDUC 2202

Please complete and return the following information concerning Clinical Experience in the public schools.

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Social Security # \_\_\_\_\_ **F.S.U. E-mail** \_\_\_\_\_

Elementary & High School Attended \_\_\_\_\_

\_\_\_\_\_

Major Field of Study in Education \_\_\_\_\_

Course Instructor \_\_\_\_\_

\*Please check the county in which you **prefer** to be placed: (This does not mean that you are guaranteed a placement in that county).

\_\_\_\_\_ Marion                      \_\_\_\_\_ Harrison                      \_\_\_\_\_ Monongalia

List days and times available for clinical work:

List Clinical Experience for other classes this semester:

I request a Clinical Experience placement as indicated above. If I drop this course, I will notify the class instructor and Director of Clinical Experiences as soon as possible.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date