The College of New Jersey

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School of Education

STEP Office

CLINICAL PRACTICE DISCONTINUANCE/REASSIGNMENT FORM

INFORMATION

Student's Name _____ College Supervisor_____

Department _____ Quarter/Semester Fall _____ Spring _____

District _____ School _____

Cooperating Teacher(s)_____

Contact Administrator _____ TCNJ Supervisor _____

Date of Discontinuance: _____

Reason: _____

_____

(Attach additional pages as necessary)

Cooperating Teacher(s) is/are in agreement with the decision? YES ____ NO ____

Supporting documentation attached? YES ____ NO ____

RECOMMENDATIONS

_____ The college supervisor and ***Department Chair*** recommend that clinical practice NOT be repeated.

_____ The college supervisor and ***Department Chair*** recommend that clinical practice* be repeated under the following conditions:

_____ reassignment in clinical practice this semester*

_____ after remediation

Recommendations for successful placement (remediation/placement/plan:

_____

_____

___

_____ _____ _____ _____

Supervisor's Signature Date Department Chair Date

ATTACHMENTS

_____ All observation reports from university supervisor

_____ Any observation reports from cooperating teacher

_____ Remediation plan for the student

*If reassignment occurs prior to midterm