



Office of Clinical Experiences & Partnerships **SECONDARY ED**
Mentor Teacher Stipend Verification Fall 2019 (August - December)

Cooperating Teacher _____ SS# _____

_____ **Check if change of name** Please Print Necessary to process checks

Home Address _____

_____ **Check if change of address** Street City State Zip Code

Home e-mail _____ Home phone _____

Are you a KU graduate? Yes ____ No ____ Year ____ Degree/Major _____

School District _____ Building _____

Grade/Subject _____ Work Email _____

Signature of Cooperating Teacher _____

KU Teacher Candidate _____

Please Print

Office Approval: Stipend _____ \$ 540.00 Date _____

(Please return this form to the CE&P Office in the self-addressed, stamped envelope.)



Office of Clinical Experiences & Partnerships **SECONDARY ED**
Mentor Teacher Stipend Verification Fall 2019 (August-December)

Cooperating Teacher _____ SS# _____

_____ **Check if change of name** Please Print Necessary to process checks

Home Address _____

_____ **Check if change of address** Street City State Zip Code

Home e-mail _____ Home phone _____

Are you a KU graduate? Yes ____ No ____ Year ____ Degree/Major _____

School District _____ Building _____

Grade/Subject _____ Work Email _____

Signature of Cooperating Teacher _____

KU Teacher Candidate _____

Please Print

Office Approval: Stipend _____ \$ 540.00 Date _____

(Please return this form to the CE&P Office in the self-addressed, stamped envelope.)