

REQUEST FOR OBSERVATIONS/CLINICAL EXPERIENCES

Laboratory School Placements
Thomas Metcalf School
University High School

Course Title _____ Course # _____ Dept. _____ (Mail Code) _____

Section # _____ Number of Students _____ Today's Date: _____

Instructor Name _____ Campus Phone _____

e-mail _____ Dept. Fax # _____

Observations for this course should occur between (Dates) _____ and _____

Number of Observations Required _____ Length of Time Per Observation _____

Total No. of Observation Hours _____

Type of Observations (grade level, subject, etc.)

Describe the assignment and **attach any forms** the ISU student will be completing during/after the observation. (This information is needed before observations request can be processed.)

ATTACH THIS REQUEST FORM TO THE STUDENTS' SCHEDULING FORMS AND RETURN TO:

Ms. Kathy Clesson

U-High (7100)

Updated August 2005

Ms. Karen Irvin

Metcalf (7000)

LSA