



**Bemidji State University**

**Clinical Experiences Program**

**Cooperating Teacher’s Recommendation**

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| --- | --- | --- | --- |
| Student Professional: |  | Date: |  |
| City/School: |  | University Supervisor: |  |
| Subject/Grade: |  | Cooperating Teacher: |  |
| CT Work Phone: |  | CT Home/Cell Phone: |  |

**The following items reflect the goals for the Bemidji State Teacher Education Program. Please comment on the preparation reflected in each area:** an appropriate image of a professional; adequate knowledge of basic skills and/or academic content areas; use of knowledge of child/adolescent development to accommodate diverse learner needs; ability to plan, facilitate, and evaluate effective cognitive/affective learning; ability to collaborate with parents and/or other professionals; and ability to grow through reflection on his/her own teaching. Comment on potential for performing the roles and functions of a professional teacher.

**Please Type**

***Cooperating Teacher Signature***

***Please be sure to sign form.***

***Save signed document as a PDF and upload into SL&L.***