

REQUEST FOR COURSE APPROVAL FOR PROFESSIONAL DEVELOPMENT

Name _____ SS# _____

Mailing Address _____

City, State, Zip _____

Are you currently teaching? YES NO
If so, what are you teaching? _____

Are you working toward adding another area of licensure? YES NO
If so, what area? _____

Are you teaching out of field? YES NO
If so, have you submitted an Additional Licensure Plan (ALP)? YES NO

I certify that the above statements are true and correct to the best of my knowledge.

Signature of Authorized **School District authority**: _____ Date: _____

I certify that the above statements are true and correct to the best of my knowledge.
Signature of **Teacher Applicant**: _____ Date: _____

COURSE NO. AND TITLE _____
UNIVERSITY _____
UNIVERSITY CREDIT HOURS _____

COURSE APPROVED _____
COURSE DISAPPROVED _____

REASON FOR DISAPPROVAL _____

Reviewed by _____ Date _____

Return to: Arkansas Department of Education
Professional Licensure
#4 Capitol Mall
Little Rock, AR 72201