



SCHOOL OF EDUCATION  
**Office of Clinical Practice-**  
*Fieldwork & Student Teaching*  
Tel. (212) 650-6915

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**WORKSITE INFORMATION**

(This form is **ONLY** for students who are currently teaching & are being allowed by CCNY their instructor to use their own classroom as their fieldwork site)

NAME: \_\_\_\_\_ STUDENT ID \_\_\_\_\_  
*Last, First*

Undergraduate \_\_\_ Graduate \_\_\_ Course Number \_\_\_\_\_ Semester \_\_\_\_\_ YEAR \_\_\_\_\_

SCHOOL/ CENTER WHERE YOU WORK

TITLE/POSITION:

\_\_\_\_\_

PRINCIPAL/DIRECTOR: (Please Print)

WORKSITE TELEPHONE

WORKSITE FAX:

\_\_\_\_\_

SCHOOL/CENTER ADDRESS: (Include Borough & Zip Code)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WORK HOURS: \_\_\_\_\_

AGE/GRADE LEVEL: \_\_\_\_\_

**DESCRIPTION OF RESPONSIBILITIES:**

*(How long have you been in the position, etc.)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTE:** *If any of the above information changes, please inform the Office of Clinical Practice.*