

Office of Licensure and Credentials
 New Jersey State Department of Education
 P.O. Box 500
 Trenton, NJ 08625-0500

OUT OF STATE ALTERNATE ROUTE PROGRAM VERIFICATION FORM

Applicant: Complete Section A of this form. Send it to the State Department of Education, Office of Teacher Certification where you completed your Alternate Route certification program. Once completed and returned to you by that state agency, forward the form and any associated material that you may have received to the New Jersey's Office of Licensure and Credentials at the above address. Only the original, signed form can be accepted.

SECTION A: TO BE COMPLETED BY APPLICANT

1. NAME	LAST	FIRST	M.I.	MAIDEN/FORMER NAME
2. ADDRESS				3. DATE OF BIRTH
CITY/STATE/ZIP				4. SOCIAL SECURITY NO.
4. TELEPHONE:				
Business ()			Home ()	

SECTION B: TO BE COMPLETED BY STATE DEPARTMENT OF EDUCATION

The above named applicant has requested New Jersey teacher licensure. The applicant has indicated that he/she has completed an alternative route to teacher certification in your state. In order to proceed with the evaluation process, we will need to verify that your program is comparable to that of New Jersey's alternative route to teacher certification. In New Jersey, the program requires that the alternate route candidate teach for 34 weeks, full time, under specified support, supervision and evaluation by school-based professionals. The alternate route teacher must also complete 200 hours of formal instruction in the knowledge and skills identified as essential for beginning teachers. The on-the-job experience occurs concurrently with the formal instruction during the teacher's first year in the classroom. Please answer the questions below to assist in the evaluation process. To be valid, this form must be signed by your Department of Education's Director of Teacher Certification. Please verify the entered information by affixing your State seal as indicated. Additionally, please include any additional information about your state's Alternative Route to teacher certification. Once completed in full, RETURN THIS LETTER TO THE APPLICANT NAMED ABOVE.

- A. Has this applicant completed your state approved alternative teacher certification program?** A. YES NO
 Date of program completion. _____
- B. Was the applicant eligible for certification in your state at the completion of his/her alternative teacher preparation program?** B. YES NO
 If no, what were the deficiencies? _____

- C. Major area and/or grade level in which applicant is recommended to teach:** _____

- D. Did the applicant teach in the subject matter/grade in which he/she received this certificate?** D. YES NO
- E. Did the program involve teaching with a trained mentor?** E. YES NO
 If yes, how long? _____
- F. Did the applicant complete a formal instruction dealing with theory and practice of teaching?** F. YES NO

Name of State	STATE OR DEPARTMENT SEAL	
Address		
City/State/Zip		
Telephone ()		Name (Printed)
Signature of Director of Teacher Certification Office		