Cleburne Independent School District
STUDENT TEACHING REQUEST

Date of request _____

Name: _____

Address: _____

Phone: _____

Email address: _____

Length of Teaching Assignment: _____

Grade Level Requested: _____

Campus Choices: (1)_____, (2)_____

If alternative program candidate,
Name of alternative program: _____

If Current Student,
Name of college/university: _____

Please allow 10 working days for your request to be processed once all documents have been submitted/received.

***Department of Curriculum & Instruction will process the request.**

Office Use Only:

Campus Assignment: _____

Date Assignment to Begin:_____

Mentor Teacher: _____