

Fieldwork Summary *(Spring 2008 Version)*

WKU CLASS _____
Year/Semester _____

WKU ID# _____ **Last Name** _____ **First Name** _____

Certification Area: P-5 P-12 5-12 Middle Grades Secondary **Major:** _____
 IECE K-12 EXED LBD/MSD School Counseling School Psychology

School/Program Name _____ **School/Program Location: City, State** _____
Teacher/Educator Name _____ **School/Program Location: County** _____
Class Name (if applicable) _____ **School/Program Location: Zip Code** _____
FIELD HOURS _____ **GRADE/AGE LEVEL/CONTENT AREA** _____

TYPES OF EXPERIENCES (CHECK all that apply)		CONTEXT (CHECK all that apply)		TYPES OF STUDENTS (CHECK all that apply)		ETHNICITY OF STUDENTS (CHECK all that apply)	
Observed	<input type="checkbox"/>	Inclusive classroom	<input type="checkbox"/>	Physically Impaired	<input type="checkbox"/>	Caucasian	<input type="checkbox"/>
Provided teacher support (research, bulletin board, supervised field trip, graded/filed, ran errands)	<input type="checkbox"/>	Resource room	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	African American	<input type="checkbox"/>
		Collaboration	<input type="checkbox"/>	Moderate/Severe Disability	<input type="checkbox"/>	Native American/American Indian	<input type="checkbox"/>
		Pullout programs	<input type="checkbox"/>	Emotional/Behavior Disorder	<input type="checkbox"/>	Latino/Hispanic American	<input type="checkbox"/>
Tutored/direct intervention	<input type="checkbox"/>	Tutorial/enrichment	<input type="checkbox"/>	Gifted	<input type="checkbox"/>	Asian American	<input type="checkbox"/>
Taught lessons	<input type="checkbox"/>	Clinic/lab	<input type="checkbox"/>	English Language Learner	<input type="checkbox"/>	Other	<input type="checkbox"/>
Interviewed	<input type="checkbox"/>	Self-contained classroom	<input type="checkbox"/>	Visually Impaired	<input type="checkbox"/>		
Consulted	<input type="checkbox"/>	Community-based	<input type="checkbox"/>	Hearing Impaired	<input type="checkbox"/>		
Administered assessment	<input type="checkbox"/>	Home-based	<input type="checkbox"/>	Speech/Language Delayed	<input type="checkbox"/>		
Provided family support	<input type="checkbox"/>	Hospital	<input type="checkbox"/>	Developmentally Delayed	<input type="checkbox"/>		
Instructional assistive technology support	<input type="checkbox"/>	Residential	<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>		
		Alternative program	<input type="checkbox"/>	Other Health Impaired	<input type="checkbox"/>		