

Para-to-Teacher Support Program

State Personnel Development Grant
Bureau of Exceptional Education and Student Services
Florida Department of Education



Annual Service Obligation Verification of Employment

PARTICIPANT NAME: _____

CONTACT INFORMATION

EMAIL: _____

PHONE NUMBER: _____

ADDRESS: _____

SCHOOL DISTRICT NAME: _____

SCHOOL NAME: _____

PRINCIPAL NAME: _____

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TO BE COMPLETED BY PRINCIPAL:

I verify that _____, is currently
Name of Participant

employed by _____, and is a teacher of exceptional students.
Name of School District

Employment began on _____.
Date

Signature of School Principal

Date