CLINICAL PRACTICE & PARTNERSHIPS SCHOOL OF EDUCATION



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Department of Early Childhood and Childhood Education

Field Experience Time Sheet

Student Name: EMPLID:

Semester: Course: ECE 311 Course Instructor:

School: Principal: Class:

School Tel. Number:

Teacher(s):

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| **Date** | **Number of Hours**  **Completed** | **Teacher Signature** |
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Total Hours: Student Signature: