VERIFICATION OF POSTSECONDARY EDUCATOR EXPERIENCE

last name	first name	middle name	maiden name

street address	city	state	zip code

social security number

▶▶ **To the employer: Please return this form to the employee. Do not send it directly to the Licensure Section.**

Professional Educator (Postsecondary) Experience (to be completed by employer)				
Name of Institution	Beginning date of quarter/semester (month, day, year)	Ending date of quarter/semester (month, day, year)	Total hours spent teaching per week each term	Position title
(PLEASE USE A SEPARATE LINE FOR EACH QUARTER/SEMESTER TAUGHT)				

I certify that this verification omits leave of absence periods and that all information is complete and correct according to the official records of the institution.

signature of institution's personnel officer ____________ date ____________ address ____________

title ____________ telephone ____________ city, state, and zip code ____________

Public Schools of North Carolina
State Board of Education
Department of Public Instruction
Licensure Section
6365 Mail Service Center
Raleigh, North Carolina 27699-6365

Form CE
March 2006