PRACTICUM SCHEDULE CONFIRMATION

JEM 492 Semester_____ Year _____

Please complete the following information. Return the complete form to Dr. Swan ***within two weeks*** of the beginning of the semester.

Student's Name: _____

Campus Address: _____

_____
City State Zip

Campus Telephone: _____

Email Address: _____

Practicum Company Name: _____

Mailing Address: _____

_____
City State Zip

Practicum Telephone: (_____)_____

Supervisor Name & Title: _____

Supervisor Email: _____

Practicum Duties:* _____

_____

Start Date: _____ Stop Date: _____

Normal Hours Per Week Scheduled: _____

_____
Print or Type Supervisor's Name

_____
Supervisor's Signature

* use back for additional space

_____
Title