



OFFICE OF SUPERINTENDENT OF PUBLIC INSTRUCTION  
 Professional Education and Certification  
 Old Capitol Building, PO BOX 47200  
 OLYMPIA WA 98504-7200  
 (360) 725-6400 TTY (360) 664-3631  
 Web Site: <http://www.k12.wa.us/certification/>  
 E-Mail: [cert@k12.wa.us](mailto:cert@k12.wa.us)

## VERIFICATION OF ADMINISTRATIVE EXPERIENCE

### SECTION I

| TO BE COMPLETED BY APPLICANT   |      |                     |        |                                   |
|--|------|---------------------|--------|-----------------------------------|
| 1. NAME  | LAST | FIRST               | MIDDLE | MAIDEN/FORMER NAME                |
| 2. ADDRESS   |      |                     |        | 3. DATE OF BIRTH                  |
| CITY/STATE/ZIP   |      |                     |        | 4. SOCIAL SECURITY NO. (OPTIONAL) |
| 5. TELEPHONE   |      |                     |        | WA CERT. NO.                      |
| BUSINESS (            )  |      | HOME (            ) |        |                                   |
| E-MAIL   |      |                     |        |                                   |
| If you are applying for the professional administrator certificate, you will need to verify appropriate experience on this form. |      |                     |        |                                   |

### SECTION II

| TO BE COMPLETED BY EMPLOYER, OR HIS/HER DESIGNEE, WHERE APPLICANT WAS EMPLOYED  |                                     |   |                                      |                             |
|---|-------------------------------------|---|--------------------------------------|-----------------------------|
| Based on personnel records, this statement <b>MUST</b> be prepared and signed by the superintendent or the personnel director of the school district, or private school. Stamped signatures <b>MUST</b> be initialed by the individual using the stamp. <u>Please return this completed form directly to the applicant.</u> |                                     |   |                                      |                             |
| SCHOOL DISTRICT   |                                     |   | APPLICANT'S POSITION TITLE           |                             |
| FROM  | TO                                  | IF PERSON SERVED IN DUAL ROLE, INDICATE PERCENTAGE OF FULL-TIME EQUIVALENCY IN EACH ROLE: | NUMBER OF DAYS OF SERVICE EACH YEAR: |                             |
| SERVICE WAS   | <input type="checkbox"/> FULL-TIME  | FROM _____ TO _____<br>(DATE) (DATE)  |                                      |                             |
| SERVICE WAS   | <input type="checkbox"/> PART-TIME  | FROM _____ TO _____<br>(DATE) (DATE)  |                                      |                             |
| SERVICE WAS   | <input type="checkbox"/> SUBSTITUTE | FROM _____ TO _____<br>(DATE) (DATE)  |                                      |                             |
| ADDRESS   |                                     |   | PRINTED NAME                         |                             |
| CITY/STATE/ZIP  |                                     |   | TITLE OF PERSON COMPLETING FORM      |                             |
| SIGNATURE   |                                     |   | DATE                                 | TELEPHONE<br>(            ) |

### RETURN COMPLETED FORM TO APPLICANT

APPLICANT: INCLUDE THIS COMPLETED FORM WITH YOUR OTHER APPLICATION FORMS. RETURN ALL APPLICATION FORMS TO THE COLLEGE/UNIVERSITY WHERE YOU ARE COMPLETING YOUR PROFESSIONAL CERTIFICATION PROGRAM.