Professional Practice Project Proposal Form
TCH 598 – Professional Practice

Date: _____

Name: _____ UID: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Project Site: _____

Email Address(s): _____

Proposed Dates for Professional Practice Project: _____

Professional Practice Project Site: _____

Professional Practice Project Address: _____

_____

Professional Practice Project Mentor: _____

Advisor/Dissertation Committee Chairperson: _____

Professional Practice Health Insurance Form is on file and attached: Yes No

Link to Health Insurance Certification form: http://healthservices.illinoisstate.edu/insurance/forms.shtml

Please address (on a separate page) the following items:

1. Describe the goals/planned outcomes for the professional practice project experience
2. Describe how these goals relate to program standards
3. Describe proposed professional practice project activities
4. Provide a calendar/timeline of activities for the professional practice project
5. Provide a statement from your advisor/dissertation committee chairperson regarding the plans for supervision
6. Describe whether this is a paying or non-paying professional practice project.

Student signature: _____

Advisor/dissertation chairperson signature: _____

Program Coordinator approval: _____ Date: _____