

Sample Verification of Access to Students with Autism

Part of Application

Date:

To Whom It May Concern:

(Insert name of School District) has employed the following individual for the 2025-- 2026 school year:

Name:

Job Title/Position:

School Site & Address:

Principal/Email:

Employer Acknowledgements:

(Please check the appropriate boxes below to verify the teacher's ability to complete the clinical practice requirements for this specialty area)

- This candidate will be employed as the teacher of record in the specialty area listed below. I acknowledge that an intern credential will not be issued, and the teacher may need a SELAP to authorize their services related to the authorization being added. *Please skip if the teaching assignment is not in the new specialty area.*
- FOR ASDAA** *(Required for all candidates adding an Autism authorization)*: I verify that the teacher will have access to students with autism spectrum disorders for purposes of supervised clinical practice.
- FOR ECSEAA** *(Required for all candidates adding Early Childhood to an existing MMSN or ESN credential)*: I acknowledge that the teacher will have access to early childhood special education students in all the following settings for purposes of supervised clinical practice (Total of 9 hours; 3 hours per setting)
 - *Infant-Toddler (Birth-3 years old)*
 - *Pre-school*
 - *Transitional Kindergarten or Kindergarten*

Name/ Title: