



**Georgia Professional Standards Commission
Intent to Offer
Georgia Teacher Alternative Preparation Program**

Provider Name (LEA or RESA): _____

Alternative Preparation Program Name: _____

Program Coordinator Name and Title: _____

Program Coordinator Address: _____

Telephone: _____ **Email:** _____

Participating Program Providers:

Provider Name	Contact Person	Telephone	Email

Estimated Number of Teacher Candidates: _____ **Anticipated Start Date:** _____

Program Information:

Previously PSC- Approved Provider (if adopting/adapting)	Date of Original PSC Program Approval

Anticipated date of complete proposal submission: _____

***Date Preferences for Onsite Review (1 to 2 days):**

1. _____ 2. _____ 3. _____

*Onsite Review will take place 4-6 months after PSC receipt of completed application proposal.

Submitted by:

Unit Head

Date