OSM PAYMENTS FOR _____ SEMESTER

LC Mentor: _____

Please pay the following teachers for student cadre support as On-Site Mentor (OSM)

OSM	School	Intern	Host Duration (16 wks/8 wks)	(Office Use Only) Payment Amount	(Office Use Only) Paid	Fee Waiver(s)	(Office Use Only) Issue Date
SUPERVISOR(s):							

LC Mentor Signature: Date:

☐ I am the Supervisor and this is included in my Workload.

☐ I am the Supervisor and this will be OVERLOAD.