Application for Teachers to Participate in the Holocaust Remembrance Project

(The project selects teachers who have limited exposure to Holocaust education resources, but exhibit a desire to teach the Holocaust)

NAME: _____

SCHOOL NAME: _____

SCHOOL ADDRESS: _____

CITY, STATE, ZIP: _____

SCHOOL PHONE: _____ HOME PHONE: _____

E-MAIL ADDRESS: _____

GRADES THAT YOU TEACH: 9 10 11 12

SUBJECT THAT YOU TEACH
____ LANGUAGE ARTS
____ SOCIAL STUDIES
____ OTHER (Please specify)

TOTAL YEARS OF TEACHING EXPERIENCE:

HAVE YOU RECEIVED ANY FORMAL TRAINING IN HOLOCAUST EDUCATION? IF SO, PLEASE EXPLAIN:

HOW MUCH TIME DO YOU DEVOTE TO HOLOCAUST EDUCATION EACH SEMESTER?

1-5 Days 6-10 Days 11-15 Days 16+ days

DO YOU PLAN TO PRESENT THE HOLOCAUST REMEMBRANCE PROJECT TO

YOUR STUDENTS THIS SCHOOL YEAR? YES NO

DO YOU PLAN TO MAKE THIS ESSAY CONTEST A CLASS ASSIGNMENT OR

OTHERWISE ENCOURAGE YOUR STUDENTS' PARTICIPATE? YES NO

BELOW, PLEASE DESCRIBE YOUR HOLOCAUST CURRICULUM, SPECIAL ACTIVITIES, FIELD TRIPS, VISITORS, ETC.

Please submit to:

Holland & Knight LLP
Attn: Holocaust Remembrance Project Committee
10 St. James Avenue
11th Floor
Boston, MA 02116