



PARALEGAL EDUCATION PROGRAM ACCREDITATION Form 4A—Faculty Member List

Submit this form to: paralegaleducation@lso.ca

Date: (MM/DD/YY): _____ Campus(es): _____

Institution Name: _____

Program Name: _____ Program Credential: _____

Program Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Email: _____

List proposed Faculty Members for all courses, alphabetically by last name. Please use the Faculty Member's full name as registered with the Law Society for Faculty Members who are Licensees.

Review the Accreditation Documents for information on teaching experience, practice experience, and full-time and part-time status and related definitions.

Attach the résumé of each listed Faculty Member.

Name (Last, First):

Qualification: Lawyer Paralegal other

LSO Licence Number (if applicable): _____

Teaching Experience: _____ years Practice Experience: _____ years

Status: Full Time Part Time

Name (Last, First):

Qualification: Lawyer Paralegal other

LSO Licence Number (if applicable): _____

Teaching Experience: _____ years Practice Experience: _____ years

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Practice Experience: years

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Status: Full Time Part Time