Italy Independent School District

Staff Development Credit Equivalency

(SDCE)

Certificate of Validation

Name:_____Your Campus:_____

Job Assignment:_____

Workshop Title:_____

Workshop Date:_____Time of Day:_____

Location of Workshop: _____Total Hours: _____

_____ _____

Principal's/Supervisor's Approval *Date*

Workshop pertained to which categories? Circle all appropriate response:

Strategic Plan	Technology	STAAR/EOC	RtI	G/T
T-PESS/T-TESS	PLC	SPED	Discipline Strategies	ELL/Bil
Perceptual Modes	Content Area	Other_____	Instructional Strategies	DIP/CIP

Directions

Please circle the number which best represents your reaction to each of the items below.
Five (5) represents the highest rating and one (1) represents the lowest.

1. There was enough time allowed for application and practice of the subject. 5 4 3 2 1
2. The material presented was current and I can use it with my students now. 5 4 3 2 1
3. What would be your overall rating of this workshop? 5 4 3 2 1

Comment?_____
_____
_____

_____ _____

Employee's Signature *Workshop Verification/Date*