

MANSFIELD 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 responses:

Strategic Plan	Technology	STAAR / EOC	RTI	G/T
Intervention	M-TOP	SPED	Discipline Strategies	ELL/Bil
Perceptual Modes	Content Area	Other _____	Instructional Strategies	PDAS

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 |

Comments? _____

Employee's Signature

Workshop Verification / Date