

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	T-TESS

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