**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*