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NEIU INTERNAL EVALUATION FOR WORKSHOP,
CONFERENCE, SEMINAR, ETC.

DIRECTIONS: Please complete and return this form to the presenters of the professional development activity. Providers must retain this form for a minimum of three (3) years for ISBE auditing purposes.

TITLE OF PROFESSIONAL DEVELOPMENT ACTIVITY	Date (Insert Date Here)
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LOCATION (Facility, City, State)	(Insert Location Here)
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NAME OF PROVIDER	(Insert Provider Here)
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Indicate the outcome of this professional development by telling us the following;

4 Strongly Agree 3 Agree 2 Somewhat Agree 1 Disagree

1. _____ This professional development impacted me as an educator, and student growth in regards to content knowledge or skills, or both?
_____ This professional development impacted me as an educator, and student socially and emotional growth, or both?
_____ This professional development aligns with my district, or school improvement plans?