CSPD ACTIVITY EVALUATION PLAN

To be completed at the beginning of the inservice activity:

Title of Inservice: _____

Strategic goal/ objective this inservice addresses:

Goal: _____

Objective/ action step: _____

Date(s) of Inservice: _____

Contact person: _____ **Phone:** _____

Address: _____

Anticipated outcomes:

1. _____

2. _____

Outcome evaluation (at time of inservice) Date:_____

Person responsible: _____

Impact evaluation (6 weeks after inservice) Date: _____

Person responsible: _____

Total number participants: _____

Job title: Special Educator_____ **General Educator** _____ **Title I** _____

Administrator_____**Parent:**_____ **Paraeducator** _____

Community Agency Personnel____ **Related Service(PT,OT,SLP,Counselor):**___

Other:_____**Please list:**_____

Total cost of inservice: _____

Overall Evaluation/ Comments about inservice:

_____

_____

_____

Recommendations for future trainings:_____

_____

_____

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