

Please complete this form and send to Jeanne Steitz at the Office of Catholic Education

**Appendix C – Documentation of Inductee Program Completion**

* The first evaluation is due at the end of the first trimester/semester
* The second evaluation is due at the end of the second trimester/semester
* The assessment must be sent to Jeanne Steitz at the Office of Catholic Education

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Last, First, MI): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FT: [ ]  PT: [ ]

School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Grade(s): \_\_\_\_\_\_\_\_\_\_\_\_\_ Subject(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We hereby certify that the above named inductee has completed the requirements of the Induction Program.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(Support Teacher’s Name – Please Print) (Date)*

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*(Support Teacher’s Signature)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(Principal Name – Please Print) (Date)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(Principal’s Signature)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(Superintendent’s Signature (Date)*

**Appendix C – Documentation of Inductee Program Completion**

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| **Orientation to the induction program** | **Date** |
| Archdiocesan (New Teacher Induction) |  |
| Local (Overview / Training at Local School) |  |

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| --- |
| **Induction In-Service(Minimum** of four related to area of teaching. Religion in-services are NOT acceptable on this form. May not include Archdiocesan New Teacher Orientation Day.) |
| **Topic** | **Provider** | **Date** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

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| --- |
| **Meetings with Mentor / Support Teacher(Minimum** of nine meetings.) |
|  **Date**  | **Date** | **Date** |
|  |  |  |
|  |  |  |
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| **Initial / Continuing Needs Assessment – Appendix A** |
| **September** [ ]  | **January** [ ]  | **May** [ ]  |