

**ILLINOIS STATE BOARD OF EDUCATION**  
 Certificate Renewal  
 100 North First Street  
 Springfield, Illinois 62777-0001

**NOTICE OF PROFESSIONAL DEVELOPMENT**

**DIRECTIONS:** An approved provider is required to submit this form to the State Board of Education no later than 30 days prior to the **initial** date of **each** of its training activities. Please complete and return to: **Division of Certificate Renewal, Illinois State Board of Education, Mail Code C-255, 100 N. First Street, Springfield, Illinois 62777.**

NAME OF PROVIDER	PROVIDER NUMBER
ADDRESS (Include Street, City, State, Zip Code)	TELEPHONE
	FAX
NAME OF CONTACT PERSON FOR THIS ACTIVITY	TITLE

TITLE OF PROGRAM, COURSE OFFERING OR TRAINING ACTIVITY: *(Limit to 70 characters)*

KNOWLEDGE OR SKILL AREA(S) ADDRESSED BY THIS ACTIVITY: *(Check all that apply; note that activities may only be offered in areas for which the provider has obtained approval.)*

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Human Development and Learning | <input type="checkbox"/> Professional Knowledge and Conduct | <input type="checkbox"/> Content Knowledge relevant to content-area standards <i>(specify areas)</i> |
| <input type="checkbox"/> Diversity                      | <input type="checkbox"/> Planning for Instruction           | _____  |
| <input type="checkbox"/> Learning Environment           | <input type="checkbox"/> Instructional Delivery             | _____  |
| <input type="checkbox"/> Communication                  | <input type="checkbox"/> Assessment                         | _____  |
| <input type="checkbox"/> Collaborative Relationships    | <input type="checkbox"/> Reflection and Professional Growth | _____  |

*(The professional teaching standards are set forth in Appendix H of the Manual.)*

Give a brief description of the program, course offering or training activity. Identify the instructional methods to be used.

What are the purposes, objectives, or learning outcomes of the program?

THIS PROFESSIONAL DEVELOPMENT ACTIVITY WILL OFFER: <input type="checkbox"/> CEUs <input type="checkbox"/> CPDUs	TARGET AUDIENCE: <i>(Who are the intended participants?)</i>
EXPECTED DURATION IN HOURS:	

**LOCATION AND TIME OF THE TRAINING ACTIVITY:**  
 Please provide the name of the facility (e.g., "Lincoln School"), if appropriate, the address where the training will occur, and the initial date and time of the activity

NAME OF FACILITY	INITIAL DATE OF TRAINING ACTIVITY	TIME OF ACTIVITY
ADDRESS (Include Street, City, State, Zip Code)	TELEPHONE	
	FAX	

SIGNATURE AND TITLE OF PERSON SUBMITTING NOTIFICATION

NAME AND TITLE OF PERSON SUBMITTING NOTIFICATION <b>(Type or Print)</b>	DATE
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**Please attach a sample program, syllabus, or outline for this seminar, workshop, institute, symposium, conference, staff development meeting or program, or other training activity.**