

WINNEBAGO COUNTY SPECIAL EDUCATION COOPERATIVE

11971 Wagon Wheel Road – Rockton IL 61072

815/624-2615 or FAX 815/624-8118

() Staff Request – District # _____ or () Staff Request – Cooperative

PRE-APPROVAL FORM FOR FLOW-THROUGH INSERVICE FUNDS

INSTRUCTIONS FOR COMPLETING THIS FORM:

1. Please complete one Pre-approval form for each inservice project.
2. Please submit the completed Pre-approval form to the above address.
3. In order to be approved for reimbursement, the inservice project must directly provide for the professional development of staff who serve handicapped students and the project must follow Federal, State and County guidelines.

INSERVICE PROJECT DESCRIPTION:

1. Date of inservice project: _____
2. State of need (demonstrating how this need relates to the Cooperative’s total Grant) and method of assessing the need: _____
3. Purpose and objectives of the project (demonstrating how the purpose and objectives relate to the Cooperative’s total Grant): _____
4. Description of the process used to achieve the purpose and objectives:
 - a. Attendee(s): _____
 - b. Conference/Inservice: _____
 - c. Location: _____
5. If a speaker is being engaged, please answer these questions:
 - a. For how much time will the presentation(s) be?
 _____ Full day(s) _____ Half day(s) _____ Hour(s)
 - b. Is the speaker from Illinois? _____ Yes _____ No
 - c. If the speaker is from out-of-state, please explain why this person was chosen instead of someone from Illinois: _____
6. Evaluation procedure (each attendee must submit the attached Inservice/Conference Dissemination/Evaluation Component within one week of the conference): _____
7. Itemization of estimated expenditures:
 Registration \$ _____ Lodging \$ _____
8. Cooperative staff is to claim mileage on monthly mileage claim.

_____ Date
 _____ Signature of District Superintendent/Designee (District Staff Only)

_____ This plan appears to meet guidelines and is approved.
 _____ In order to consider approval, the following information is necessary:
 _____ This plan does not appear to meet guidelines and is not approved because:

_____ Date
 _____ Signature of Director of Special Education

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POST INSERVICE /CONFERENCE DISSEMINATION/EVALUATION COMPONENT

1. Staff Name: _____ Date: _____

2. Inservice/Conference Title: _____

3. Dates of Inservice: _____

4. Please describe the conference highlights:

5. Please identify how and to whom the information will be disseminated:

6. Please identify how the material learned will be applied to your position:

7. Please attach a **copy** of the Official CPDU/CEU Evidence of Completion form:

Return this form to the Director along with any requests for reimbursement within one week of the inservice/conference.