San Mateo-Foster City School District *Option III Form 1*
Individualized Certificated Evaluation Plan

Name_____ Date_____

Evaluator_____

Professional Goal/s Subject _____

Plan:

Support Needed:

Anticipated Impact on Students:

Evidence:

San Mateo-Foster City School District *Option III Form 2*

Observation of Specialist Teacher

Teacher: _____ Grade: _____ Subject: _____

Date: _____ Time: From _____ to _____

Pre-conference: Date: _____

Post-conference: Date: _____ From _____ to _____

Goal(s):

Observations related to the Goals:

Comments and Recommendations:

_____ _____

Observer's Signature Date

_____ _____

Evaluatee's Signature Date

The evaluatee's signature does not constitute an endorsement of the Evaluator's statements; only that this evaluation has been received. Written comments may be made by the Evaluatee. It is recommended that such comments be submitted to the Evaluator within ten days. Such comments will be forwarded to the Human Resources Office and attached to this evaluation.

Rev. 1/03

San Mateo-Foster City School District *Option III Form 3*
Certificated Evaluation
Evaluation Report Final Conference

I Evidence of Goal Completion provided by Evaluatee:

II Comments by Evaluatee:

III Comments and Documentation by Evaluator:

IV Summary Evaluation Rating:

_____ Exemplary _____ Satisfactory

_____ Needs Improvement _____ Unsatisfactory

_____ _____
Evaluatee's Signature Date

_____ _____
Evaluator's Signature Date

Rev. 1/03