## MASSACHUSETTS DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION

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| Request for Comprehensive System of Personnel Development (CSPD) Training *Please Note: Submission of this request is not a guarantee of training.* | | | |
| District/Agency Information **District/Agency:**    **Contact Person: Role:**  **Address:**  **Telephone Number: Fax Number:**  **E-mail Address:** | | | |
| Presentation Information **Module Being Requested:** | | | |
| **Possible Date: 1st choice** | **Start / End Time:** | **Possible Date: 2nd choice** | **Start / End Time:** |
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| Justification of Request  1. **List district(s)/agency(ies) that will participate in training.** | | | | |
| 1. **Describe how the requested training will augment ongoing professional development activities. (Attach additional sheets if necessary.)** | | | | |
| 1. **Is this request being made as part of a Corrective Action Plan (CAP)?**   **No**  **Yes If yes, list special education criterion number(s) to be addressed.** | | | | |
| 1. **Describe target audience by checking all that apply and by indicating probable numbers of participants.**   **General Educators: #\_\_\_\_\_\_\_\_\_\_ General Education Administrators: #\_\_\_\_\_\_\_\_\_\_**  **Special Educators: #\_\_\_\_\_\_\_\_\_\_ Special Education Administrators: #\_\_\_\_\_\_\_\_\_\_**  **Related Service Providers: #\_\_\_\_\_\_\_\_\_\_ Paraprofessionals: #\_\_\_\_\_\_\_\_\_\_**  **Other: #\_\_\_\_\_\_\_\_\_\_ Describe:** | | | | |
| Authorized by Special Education Director / Agency Representative **Name: Role:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature Date** | | | | |