

**EVIDENCE OF COMPLETION FOR  
PROFESSIONAL DEVELOPMENT**

100 North First Street, E-240  
Springfield, Illinois 62777-0001

**EDUCATOR EFFECTIVENESS DEPARTMENT**

This is to certify that the undersigned has completed the professional development activity described herein and that the provider is approved by the state superintendent of education at the time of completion. This form serves as evidence to verify participation in this professional development activity and must be maintained for a period of six years by the licensee and produced if requested as part of an audit.

**IMPORTANT: THE LICENSEE MUST ENTER THE ACTIVITY INTO THE EDUCATOR LICENSURE INFORMATION SYSTEM (ELIS) BY AUGUST 31 OF THE LICENSE RENEWAL YEAR. LICENSEES RETAIN THIS FORM FOR SIX YEARS FOR AUDITING PURPOSES. DO NOT SUBMIT THE FORM TO ISBE UNLESS THE AGENCY REQUESTS YOU TO DO SO.**

LEGAL NAME OF PARTICIPANT (Last, First, Middle Initial)	AFFIRMED NAME OF PARTICIPANT (if applicable) (Last, First, Middle Initial)
TITLE OF PROFESSIONAL DEVELOPMENT	IEIN
DATE(S) OF ACTIVITY	
NAME OF APPROVED PROVIDER (Enter in ELIS)	REGION, COUNTY, DISTRICT, TYPE (RCDT) CODE (Form is invalid without a state-approved provider RCDT code)
NAME OF THIRD-PARTY PRESENTER/ORGANIZATION AUTHORIZED BY A STATE-APPROVED PROVIDER ABOVE (If used)	
NAME OF PRESENTER(S) (Do not enter into ELIS)	
NUMBER OF PROFESSIONAL DEVELOPMENT HOURS AWARDED	

IS THIS ACTIVITY A STATE-MANDATED TRAINING?  YES  NO

\_\_\_\_\_  
*Signature of Approved Provider's Representative*

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Signature of Participant's Legal Name*

\_\_\_\_\_  
Date

\_\_\_\_\_  
*Signature of Participant's Affirmed Name (if applicable)*

\_\_\_\_\_  
Date