

Warren County Special Services School District
1500 Route 57, Suite 1
Washington, NJ 07882
Tel. 908-835-1004 Fax 908-835-1042

PROFESSIONAL DAY

Staff Member Name _____ Date ____/____/____

Title of In-Service Conference/Workshop _____

Sponsoring Organization _____ Date ____/____/____

Location of Workshop _____ Time _____

Substitute Required: No Yes Full Day Half Day

Cost of Registration \$ _____

Distance (Estimate) _____ Miles

Number of conferences/workshop attended this year _____

Written description of conference or workshop (attach any pertinent information):

Written statement as to how the conference/workshop attendance will specifically benefit your students.

Would you recommend a presentation by yourself to the staff in regard to this workshop?

Yes No Briefly explain whether answer is yes or no.

Approved Not Approved _____
Principal Date

Approved Not Approved _____
Superintendent Date

Signature of Requesting Teacher/Therapist _____