Department of Education

SCHOOL LEADERSHIP TEAM ANNUAL EVALUATION FORM

School Name:	Level: ___ ES ___ MS ___ HS	Year:
Parent Representative:	___ Mandatory ___ Elected	
Date:	Years Served on SLT: ___ 0-1 ___ 1-3 ___ 4+	

SCHOOL LEADERSHIP TEAM (SLT) ASSESSMENT OF PRINCIPAL FORM

School Name:	Level: ___ ES ___ MS ___ HS	Year:
Parent Representative:	___ Mandatory ___ Elected	
Date:	Years Served on SLT: ___ 0-1 ___ 1-3 ___ 4+	

Please rate the principals' performance in developing an effective shared decision-making relationship with the School Leadership Team (SLT) during the year based upon your experience as an SLT member.

Excellent ___ Very Good ___ Good ___ Satisfactory ___ Needs Improvement ___

COMMENTS:

_____

_____

_____

_____

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_____

I have read and understand the contents of this document. I certify that the answers are based on my own experiences.

_____ _____
Parent/Staff Name Signature/Date

This evaluation has been received by the Department of Education.

_____ _____
Print Name Signature/Date