

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
 Office of Teaching Initiatives
 89 Washington Avenue
 Albany, New York 12234
www.highered.nysed.gov/tcert

Completion of Approved Continuing Teacher and Leader Education (CTLE) Hour(s) Certificate

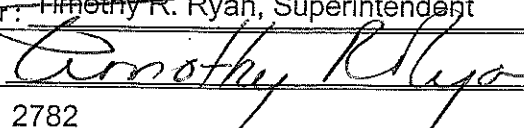
All CTLE must be completed with Approved Sponsors and be reported using this form in addition to any electronic reporting requirements.

Instructions for the Trainee:

Please complete Section I and retain your copies for eight years. It is not necessary to send a copy of this form to the Office of Teaching Initiatives unless it is requested in the event of an audit or for use in obtaining an Initial Reissuance. A separate form must be completed for each training.

Instructions for the Approved CTLE Sponsor:

Please complete Sections II and III. These sections must be completed by the Approved CTLE Sponsor authorized individual. Sponsors must verify that the trainee completed the activity, the title, date(s) and number of hours awarded. Records must be retained for a period of eight years. You may use an alternative form or format, however that alternative must capture the same information that is requested on this form.

Section I:			
First Name:	Last Name:	Middle Initial:	
Date of Birth: _____/_____/_____	Last 4 Digits of the Social Security Number: _____		
Section II			
Name of Venue: Bainbridge-Guilford Central School District			
Street Address: 18 Juliard Street	City: Bainbridge	State: NY	Zip Code: 13733
CTLE Activity Title: <u>Teacher Professional Development Days</u> <small>(Indicate title/subject/grade level, etc.)</small>			
Select One or More Areas of Activity: <input checked="" type="checkbox"/> Pedagogy <input checked="" type="checkbox"/> Content <input type="checkbox"/> English Language Learning			
CTLE Date(s): from: <u>9 / 4 / 2018</u> to: <u>9 / 5 / 2018</u>		Number of hours awarded <u>12</u>	
<small>(mm) (dd) (yyyy)</small>		<small>(mm) (dd) (yyyy)</small>	
Section III			
I certify that the individual listed in Section I completed the CTLE cited above pursuant to Subpart 80-6 of the Regulations of the Commissioner of Education.			
Approved Sponsor Name: Bainbridge-Guilford Central School District			
Print Name of Authorized Certifying Officer: Timothy R. Ryan, Superintendent			
Signature of Authorized Certifying Officer: 			
Approved Provider Identification Number: 2782		Date: <u>12/5/18</u>	
Email: <u>tryan@bgcsd.org</u>		Phone #: <u>607-967-6321</u>	

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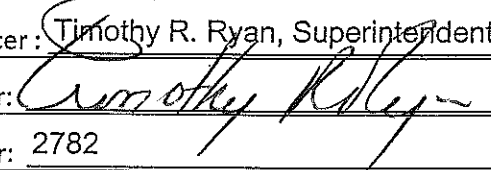
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Section I:			
First Name:	Last Name:	Middle Initial:	
Date of Birth:	Last 4 Digits of the Social Security Number:		
Section II:			
Name of Venue: Bainbridge-Guilford Central School District			
Street Address:	City:	State:	Zip Code:
18 Juliard Street	Bainbridge	NY	13733
CTLE Activity Title: <u>September Faculty Meeting</u> <small>(Indicate title/subject/grade level, etc.)</small>			
Select One or More Areas of Activity: <input checked="" type="checkbox"/> Pedagogy <input checked="" type="checkbox"/> Content <input type="checkbox"/> English Language Learning			
CTLE Date(s): from:		Number of hours awarded	
9 / 12 / 18 <small>(mm) (dd) (yyyy)</small>		1	
Section III:			
I certify that the individual listed in Section I completed the CTLE cited above pursuant to Subpart 80-6 of the Regulations of the Commissioner of Education.			
Approved Sponsor Name: Bainbridge-Guilford Central School District			
Print Name of Authorized Certifying Officer: Timothy R. Ryan, Superintendent			
Signature of Authorized Certifying Officer: 			
Approved Provider Identification Number: 2782		Date: 12/5/18	
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Section I:			
First Name:	Last Name:	Middle Initial:	
Date of Birth: / /	Last 4 Digits of the Social Security Number:		
Section II:			
Name of Venue: Bainbridge-Guilford Central School District			
Street Address: 18 Juliand Street	City: Bainbridge	State: NY	Zip Code: 13733
CTLE Activity Title: Curriculum Alignment AM/Technology PD PM <small>(Indicate title/subject/grade level, etc.)</small>			
Select One or More Areas of Activity: <input checked="" type="checkbox"/> Pedagogy <input checked="" type="checkbox"/> Content <input type="checkbox"/> English Language Learning			
CTLE Date(s): from: 10/5/18 to 10/5/18 <small>(mm) (dd) (yyyy) (mm) (dd) (yyyy)</small>		Number of hours awarded 6	
Section III:			
I certify that the individual listed in Section I completed the CTLE cited above pursuant to Subpart 80-6 of the Regulations of the Commissioner of Education.			
Approved Sponsor Name: Bainbridge-Guilford Central School District			
Print Name of Authorized Certifying Officer: Timothy R. Ryan, Superintendent			
Signature of Authorized Certifying Officer: <i>Timothy R. Ryan</i>			
Approved Provider Identification Number: 2782		Date: 12/5/18	
Email: tryan@bgcsd.org		Phone #: 607-967-6321	

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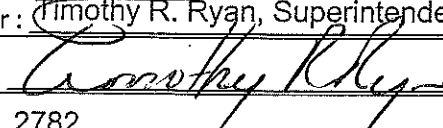
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Section I:			
First Name:	Last Name:	Middle Initial:	
Date of Birth:	Last 4 Digits of the Social Security Number:		
Section II:			
Name of Venue: Bainbridge-Guilford Central School District			
Street Address:	City:	State:	Zip Code:
18 Juliand Street	Bainbridge	NY	13733
CTLE Activity Title: <u>October Faculty Mtg.</u> <small>(Indicate title/subject/grade level, etc.)</small>			
Select One or More Areas of Activity: <input checked="" type="checkbox"/> Pedagogy <input checked="" type="checkbox"/> Content <input type="checkbox"/> English Language Learning			
CTLE Date(s): from: <u>10 / 10 / 18</u>		to: <u>10 / 10 / 18</u>	
<small>(mm) (dd) (yyyy)</small>		<small>(mm) (dd) (yyyy)</small>	
Number of hours awarded			<u>1</u>
Section III:			
I certify that the individual listed in Section I completed the CTLE cited above pursuant to Subpart 80-6 of the Regulations of the Commissioner of Education.			
Approved Sponsor Name: <u>Bainbridge-Guilford Central School District</u>			
Print Name of Authorized Certifying Officer: <u>Timothy R. Ryan, Superintendent</u>			
Signature of Authorized Certifying Officer: 			
Approved Provider Identification Number: <u>2782</u>		Date: <u>12/15/18</u>	
Email: <u>tryan@bgcsd.org</u>		Phone #: <u>607-967-6321</u>	

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Section I:			
First Name:	Last Name:	Middle Initial:	
Date of Birth: _____ / _____ / _____	Last 4 Digits of the Social Security Number: _____		
Section II			
Name of Venue: _____			
Street Address:	City:	State:	Zip Code:
CTLE Activity Title: <u>November Faculty District Mtg /SEL PD</u> <small>(Indicate title/subject/grade level, etc.)</small>			
Select One or More Areas of Activity: <input checked="" type="checkbox"/> Pedagogy <input checked="" type="checkbox"/> Content _____ English Language Learning			
CTLE Date(s): from: <u>10 / 28 / 18</u>		to <u>10 / 28 / 18</u> Number of hours awarded <u>1</u>	
<small>(mm) (dd) (yyyy)</small>		<small>(mm) (dd) (yyyy)</small>	
Section III			
I certify that the individual listed in Section I completed the CTLE cited above pursuant to Subpart 80-6 of the Regulations of the Commissioner of Education.			
Approved Sponsor Name: _____			
Print Name of Authorized Certifying Officer: <u>Timothy Sheer</u>			
Signature of Authorized Certifying Officer: _____			
Approved Provider Identification Number: _____		Date: <u>12/5/18</u>	
Email: _____		Phone #: _____	