

M.S.A.D. #50 TEACHER ACTION PLAN (TAP)

Name:

Address:

Position/School:

Certificate presently held (check one):

Conditional (one-year)_____ Provisional (two-year)_____

Level/Endorsement:

Expiration Date:

Type of certificate that you are applying for:

Support Team Members:

Date plan approved by Support System Steering Committee:

Signature of Support System Steering Committee Chairperson:

Completion date of plan:

Recommendation of Support Team:

Signature of Support Team Chairperson:

Standard Chosen (List standard and its title taken from “Standards for Professional Growth Leading to Competency” found on pages 15-19 in the Support System Handbook):

A copy of the standards and objectives may be used. You may add objectives of your own.

Objective 1:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 2:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 3:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 4:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 5:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 6:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 7:

Activities to meet this objective:

Resources to be used:

Documentation for this objective:

Objective 8:

Activities to meet this objective:

Resources to be used:

Documentation for this objective: