STUDENT SERVICE VALIDATION
CECIL COUNTY PUBLIC SCHOOLS

PLEASE PRINT OR TYPE:

Student Name _____
Last First Middle Initial

School _____ Gr. 9 10 11 12

Activity _____

Type (circle one) Direct Indirect Advocacy

Date: (mm/dd/yy) Start _____/_____/_____ Finish _____/_____/_____

Sponsoring Class/Organization _____

Project Supervisor _____

Phone Number _____ Hours of Service Performed _____

Student Service is comprised of three elements:

PREPARATION (describe how you prepared or received training for this type of service)

_____
_____
_____
_____

ACTIONS (Briefly explain what you did and where.)

_____
_____
_____
_____

REFLECTION (What did you do to evaluate the effectiveness of your service? How did you and your community benefit from your service?)

_____
_____
_____
_____

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Adult Site/Project Supervisor Signature Date

_____ _____
Student Service Coordinator Signature Date