



# St. Michael Catholic Secondary School

240 Oakdale Avenue  
Stratford, Ontario N5A 7W2  
Phone (519) 271-0890  
Fax (519) 271-8250

**Student Name:** \_\_\_\_\_

## SUPERVISOR'S REPORT

**CHRISTIAN SERVICE EVALUATION** *(to be filled in by the student's supervisor)*

I, \_\_\_\_\_, confirm that the above student completed \_\_\_\_\_ hours.  
(Supervisor signature)

His/Her duties were: \_\_\_\_\_

The service was performed from \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_ Phone

#: \_\_\_\_\_  
(Please print first and last name) Email:

Please use the following scale to assess the student's contribution:

<b>SCALE:</b>	<b>1 SELDOM</b>	<b>2 USUALLY</b>	<b>3 ALWAYS</b>	<b>NA</b>
A) PUNCTUAL	1	2	3	NA
B) COURTEOUS	1	2	3	NA
C) RESPONSIBLE	1	2	3	NA
D) RELIABLE	1	2	3	NA
E) WILLINGNESS TO SERVE	1	2	3	NA
F) WILLINGNESS TO LEARN	1	2	3	NA

How has this service benefitted you and your organization?

\_\_\_\_\_

Do you have any suggestions of how we can improve our Christian Service program at St. Michael Catholic School? \_\_\_\_\_

\_\_\_\_\_

Would your organization like to be put on our list? If so, please tell us your:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Needs: \_\_\_\_\_