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Compensation Survey 2026-2027

School District Name: _____
County-District Code: _____
District Contact: _____
Contact Title: _____ Phone: _____

Salary and Workdays

Provide copies of your 2026-2027 salary schedules for **certified staff/teachers** and **classified/support staff.**

Teacher Contract Days: _____ days per year Teacher Workday: _____hours per day (if different than 7.5 hours)
Student Attendance Days: _____ days per year Do you have a 4-day school week? ____Yes ____No
Transfer Credit: [] Year for year – unlimited [] Year for year – up 10 years [] Year for year – up to 7 years
[] Year for year – up to 5 years [] Year for year – up to 3 years [] Other: please explain _____

Health Insurance

Provider: [] Blue Cross [] United Healthcare [] MEUHP [] Self-Insured [] AETNA [] Cigna [] Other_____

Fill in the premium amounts for the health plans offered by the school district. If the district does not pay a portion of the plan, enter zero (0). If the district does not offer the plan, leave it blank.	**Plan I:** [] HMO [] PPO [] HSA/High Deductible			**Plan II:** [] HMO [] PPO [] HSA/High Deductible			**Plan III:** [] HMO [] PPO [] HSA/High Deductible		
	Monthly Cost to **District**	Monthly Cost to **Employee**	Monthly Premium **Total**	Monthly Cost to **District**	Monthly Cost to **Employee**	Monthly Premium **Total**	Monthly Cost to **District**	Monthly Cost to **Employee**	Monthly Premium **Total**
Employee Only/Single	$	$	$	$	$	$	$	$	$
Employee + Spouse/2-Party	$	$	$	$	$	$	$	$	$
Employee + Family	$	$	$	$	$	$	$	$	$
Employee + Child(ren)	$	$	$	$	$	$	$	$	$
Please attach the one-page Summary Plan Description for each health plan.	Annual Deductible (In-Network) Single $_____ Family $_____ Office Visit Co-pay $_____ Co-insurance _____%			Annual Deductible (In-Network) Single $_____ Family $_____ Office Visit Co-pay $_____ Co-insurance _____%			Annual Deductible (In-Network) Single $_____ Family $_____ Office Visit Co-pay $_____ Co-insurance _____%		

Paid Leave and Substitute Pay

Leave Type	Days per Year	Max Accumulation
Medical/Sick		
Personal		
Miscellaneous*		
Professional Development		
New Teacher Orientation		
Bereavement		

**Instead of having a set number of sick, personal, or other leave, the district has combined the days for the employee to use as needed.*

Leave Type	Days per Year	Max Accumulation
Jury Duty/Civic Duty		
Association Business		
Paid Holidays		
Check all that apply: [] Labor Day [] Thanksgiving/Friday after [] Christmas Eve [] Christmas Day [] New Year's Eve [] New Year's Day [] Martin Luther King Jr. Day [] President's Day [] Easter/Passover/Good Friday [] Memorial Day [] Independence Day		

Substitute Teacher Pay: Daily Rate $_____

Supplemental Benefits

Which of the following does your school district offer to instructional staff? (Check all that apply.)

	Dental Insurance		Tuition Reimbursement Amount $_____		Health Savings Account
	Disability Insurance		Cafeteria Plan/Flexible Spending Account		Children of employees may attend the same school/district tuition-free.
	Life Insurance		Plan Time/Period Minutes per week: _____(EL) _____(MS/HS)		
	Vision Insurance		Professional Liability Insurance		Health Club / Gym Membership
	Duty-free lunch		Sick Leave Pool		Early Retirement Incentive

Additional Compensation / Stipends

Does your school district offer extra pay for sponsoring extracurricular activities? (Coaching, speech & debate, etc.) *If so, please enclose a copy of the pay schedule or enter stipend amounts online.* [] Yes [] No

Does your school district offer extra pay for National Board Certification, or other certifications such as social worker, speech language pathologist or physical/occupational therapist? [] Yes [] No
If so, please list annual stipends. _____

In determining compensation, which of the following does your district use?
[] Collective bargaining [] Meet and confer [] Salary committee with employee representatives [] None of the above
Which group(s) represent district employees? _____