Insert School Logo Here

Office of Special Services
SCHOOL NAME
STREET ADDRESS
CITY, STATE
Phone: _____ Fax: _____

Request for Special Education Records

DATE: _____
TO: _____**, DEPT OF SPECIAL SERVICES**
FROM: SPECIAL EDUCATION DEPARTMENT, SCHOOL NAME

Pupil: _____

Birthdate: _____
Purpose of request: To develop an appropriate educational program

PLEASE FAX ALL REQUESTED SPECIAL EDUCATION RECORDS FOR THE ABOVE STUDENT(S) TO SCHOOL NAME , ATTN TO INTAKE PERSONNEL NAME AT FAX NUMBER

- **Psychological Evaluation**
- **IEP/LRE**
- **COSF**
- **Re-evaluation Review Plan**
- **FBA/BIP**

Thank you for your cooperation.

Per Federal Law 99:31
Revised 6/30/2016

School Use Only:

1st Request_____
2nd Request_____

INSERT SCHOOL LOGO

Office of Special Services
SCHOOL NAME
STREET ADDRESS
CITY, STATE

Phone: _____Fax: _____

Fax Cover Sheet

TO: _____
FAX NO:_____
FROM:_____
DATE:_____

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