

Insert School Logo Here

Office of Special Services

SCHOOL NAME

STREET ADDRESS

CITY, STATE

Phone: Phone: Fax: 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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