

The University of the State of New York
THE STATE EDUCATION DEPARTMENT
Office of Vocational and Educational Services for Individuals with Disabilities
Room 1621 - One Commerce Plaza
Albany, NY 12234
(518) 473-6108
(518) 473-5769 Fax

APPLICATION TO THE COMMISSIONER OF EDUCATION
FOR APPROVAL FOR AN EVALUATION TO ATTEND
A 4201 STATE-SUPPORTED SCHOOL
PHC-10

INSTRUCTIONS

1. Please PRINT or TYPE the information on this application.
2. The appropriate examination(s) as listed below, administered within the last 12 months, must be submitted with this form to determine the student's eligibility.
 - Deaf student - audiogram
 - Functionally Deaf student - audiogram
 - Blind student - ophthalmological examination
 - Physically Disabled student - medical/therapy reports
 - Emotionally Disturbed student - psychological and/or psychiatric examination
 - Deaf-Blind student - audiological and ophthalmological

NOTE: During the processing of this Application it is necessary that your child remain in his or her current placement to ensure the continuity of his/her educational program.

For further assistance in completing this application please contact the Office listed above.

1. Child's Name _____ 2. Date of Birth ____ / ____ / ____ F M
(Last) (First)
3. Parents'/Guardians Names _____
4. Address _____
(Street) (City) (State) (Zip Code)
County of Location _____
5. Telephone Number () _____
6. Local School District of Residence _____
Address _____
(Street) (City) (State) (Zip Code)
Telephone Number () _____ Fax () _____
7. Indicate the dominant language used in the home: _____

8. Indicate child's primary disability (*check only one*)

- | | | | |
|-------------------------|--------------------------|----------------------------|--------------------------|
| Deaf | <input type="checkbox"/> | Legally Blind | <input type="checkbox"/> |
| Functionally Deaf | <input type="checkbox"/> | Physically Disabled | <input type="checkbox"/> |
| Blind | <input type="checkbox"/> | Emotionally Disturbed..... | <input type="checkbox"/> |
| Deaf/Blind | <input type="checkbox"/> | | |

9. If child has multiple disabilities (check all that apply)

- | | | | |
|-----------------------------|--------------------------|-------------------------------|--------------------------|
| Mentally Retarded | <input type="checkbox"/> | Hard of Hearing | <input type="checkbox"/> |
| Autistic | <input type="checkbox"/> | Visually Impaired | <input type="checkbox"/> |
| Emotionally Disturbed | <input type="checkbox"/> | Orthopedically Impaired | <input type="checkbox"/> |
| Speech Impaired | <input type="checkbox"/> | Other Health Impaired | <input type="checkbox"/> |
| Deaf | <input type="checkbox"/> | | |

10. Indicate **current** educational placement of child.

School Name _____ Phone () _____

Program Administrator _____

Address _____

(Street) (City) (State) (Zip Code)

PERSON COMPLETING THIS APPLICATION

NAME _____

TITLE _____

PHONE _____

Date Signature of Parent or Guardian

SED Use Only

Dear Parent(s):

Your child has been recommended and approved for an evaluation at the 4201 State-supported school indicated below. This office has approved this evaluation to be conducted for your child at the State-supported school effective as of the date of this approval. It will be necessary for you to contact the State-supported school indicated below to make the necessary arrangements so that your child may be evaluated promptly. The results of this evaluation will be forwarded to your school district Committee on Special Education/Committee on Preschool Special Education for their review.

Should you have any questions, please contact this office at (518) 473-6108.

Sincerely,

Signature of State Representative Date

cc: CSE CPSE REGION CBST

4201 School _____