

The University of the State of New York  
THE STATE EDUCATION DEPARTMENT  
Office of Vocational and Educational Services for Individuals with Disabilities  
Special Education Quality Assurance

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

State-operated School (indicate which school you are applying to):

New York State School for the Blind (NYSSB)

New York State School for the Deaf (NYSSD)

**INSTRUCTIONS**

1. Please PRINT or TYPE the information on this application.
2. Submit the following medical documentation with this application:

**For a child who is Blind (a minimum of one of the following documents must be submitted):**

- Current ophthalmologic examination (administered within the last 12 months)
- New York State Commission for the Blind and Visually Handicapped (CBVH) report indicating legal blindness

**For a child who is Deaf:**

- **Current audiogram (administered within the last 12 months)**

3. Submit the following school/educational information with this application (if available):

- Current Individualized Education Program (IEP)
- Physical examination report
- Psychological exam/report
- Social History
- Any additional appropriate information

4. For a child who is Blind send a completed application and required documentation to the attention of:

Mr. Christopher Suriano  
VESID, SEQA  
2A Richmond Avenue  
Batavia, NY 14020

For a child who is Deaf send a completed application and required documentation to the attention of:

Ms. Suzanne Jackson  
VESID, SEQA  
333 East Washington Street, Suite 527  
Syracuse, NY 13202

**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 appropriate Office listed above.

1. Child's Name: \_\_\_\_\_ 2. Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  F  M  
(Last) (First)
3. Parent(s)/Guardian(s) Name(s): \_\_\_\_\_
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*):  
Blind .....  Functionally Deaf .....   
Deaf .....  Legally Blind .....   
Deaf/Blind .....
9. If child has multiple disabilities (*check all that apply*):  
Autistic .....  Orthopedically Impaired .....   
Emotionally Disturbed .....  Other Health Impaired .....   
Hearing Impaired .....  Speech Impaired .....   
Learning Disabled .....  Traumatic Brain Injury .....   
Mentally Retarded .....  Visually Impaired .....
10. Indicate **current** educational placement of child.  
School Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Program Administrator: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

11. Person completing this application (If different than Parent or Guardian):

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

Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

12.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Date

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**SED Use Only:**

Date Received:
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