



Application Instructions for PHC-10 Application to the Commissioner of Education for Approval for an Evaluation to Attend a New York State-Operated School

INSTRUCTIONS

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

For a child with Blindness, 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 with Deafness, submit:

- Current audiogram, administered within the last 12 months
3. Submit the following school/educational information with this application (if available; if your child is currently in a preschool or school age program for children with disabilities):
 - Current Individualized Education Program (IEP)
 - Physical examination report
 - Psychological examination/report
 - Social history
 - Any additional appropriate information

Application Submission Information

While electronic submissions are preferred, NYSED's e-mail server cannot guarantee secure transmittal of e-mail messages at this time. Please consult with your Information Technology staff and if your e-mail server allows for transmitting electronic messages securely via Transport Layer Security (TLS) protocols, you can submit applications electronically. If you cannot send an e-mail securely via TLS, in order to protect student confidential information, you must mail or fax the application. Select one method for submission (e-mail or mail or fax).

E-mail (if transmitting via TLS):
NYSSBNYSSD@nysed.gov

OR

Mail to:

New York State Education Department
Special Education Quality Assurance
Nondistrict Unit, Room 309 EB
89 Washington Avenue
Albany, New York 12234
Attn: State-operated PHC-10 application

OR

Fax: (518) 473-5769

For further assistance in completing this application, please contact the Nondistrict Unit at (518) 473-1185 or NYSSBNYSSD@nysed.gov.



**PHC-10 Application to the Commissioner of Education
for Approval for an Evaluation to Attend a New York State-Operated School**

State-operated school (indicate which school you are requesting to conduct an evaluation:

- New York State School for the Blind (NYSSB)
 New York State School for the Deaf (NYSSD)

1. Child's Name: [Click here to enter text.](#)
(Last/First/Middle)

2. Date of Birth: [Click here to enter a date.](#) Gender: F M

3. Parents/Guardians Names: [Click here to enter text.](#)

4. Address (include apartment number, if applicable):

[Click here to enter text.](#)
(Street/City/State/Zip Code)

County of Location: [Click here to enter text.](#)

5. Telephone Number: [Click here to enter text.](#)
(Area Code)(Telephone Number)

6. Name of School District of Residence: [Click here to enter text.](#)

7. Is the child a resident of New York State? Yes No

If no, explain: [Click here to enter text.](#)

8. Indicate the dominant language used in the home: [Click here to enter text.](#)

What additional languages (if any) are spoken in the home? [Click here to enter text.](#)

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

Name of School District/BOCES: [Click here to enter text.](#)

Telephone Number: [Click here to enter text.](#)
(Area Code)(Telephone Number)

Program Administrator: [Click here to enter text.](#)

Address: [Click here to enter text.](#)
(Street/City/State/Zip Code)



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

a. Primary Disabling Condition (*check only one*)

- Deafness Blindness Deaf-blindness

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

- | | |
|--|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Orthopedic Impairment |
| <input type="checkbox"/> Emotional Disturbance | <input type="checkbox"/> Other Health Impairment |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech or Language Impairment |
| <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Visual Impairment |

Application Completed By: [Click here to enter text.](#)

Title: [Click here to enter text.](#)

Place of Employment: [Click here to enter text.](#)
(if completed by someone other than parent)

Telephone: [Click here to enter text.](#)
(Area Code)(Telephone Number)

Signature of parent/legal guardian:

Date: [Click here to enter a date.](#)



For NYSED Office Use Only

Date Received:	
_____	_____
Signature	Date