THE STATE EDUCATION DEPARTMENT / THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

OFFICE OF SPECIAL EDUCATION
SPECIAL EDUCATION QUALITY ASSURANCE
NONDISTRICT UNIT
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Telephone (518) 473-1185 Fax: (518) 473-5769
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1 Park Place, 3rd Floor, Peekskill, NY 10566
Telephone (914) 940-2900 Fax: (914) 402-2180

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

INSTRUCTIONS

Please PRINT or TYPE the information on this application.

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.

Categories of Disability	Examination(s) Required
Deafness	Audiogram
Functional Deafness	Audiogram
Blindness	Ophthalmological examination
Orthopedic Impairment	Medical/therapy reports
Emotional Disturbance	Psychological and/or psychiatric examination
Deaf-Blindness	Audiogram and Ophthalmological examination

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 education program.

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

Child's Name:_____ DOB:_____ ☐ F ☐ M
(Last) (First)

Parents'/Guardians' Names: _____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

County of Location: _____

Telephone Number: _____

Local School District of Residence: _____

Contact Person: _____

Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Telephone Number:_____ Fax Number:_____

Indicate the dominant language used in the home: _____

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

If no, explain: _____

Indicate the child's primary disability (*check only one)*:

- ☐ Deafness
- ☐ Functional Deafness
- ☐ Blindness
- ☐ Deaf-Blindness
- ☐ Visual Impairment
- ☐ Orthopedic Impairment
- ☐ Emotional Disturbance

If the child has multiple disabilities, check all that apply:

- ☐ Intellectual Disability
- ☐ Autism
- ☐ Emotional Disturbance
- ☐ Speech or Language Impairment
- ☐ Deafness
- ☐ Hearing Impairment
- ☐ Visual Impairment
- ☐ Orthopedic Impairment
- ☐ Other Health Impairment
- ☐ Traumatic Brain Injury

Indicate the **current** educational placement of the child:

School Name: _____ Telephone Number: _____

Program Administrator: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Person Completing this Application

Name: _

Title: _

Phone Number: _

_____ 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 its review. If you have any questions, please contact this office at 518-473-1185.

Sincerely,

_____ Signature of Representative

_____ Date

c: ☐ CSE ☐ CPSE ☐ NYC CBST

4201 School: _____