



OFFICE OF SPECIAL EDUCATION
SPECIAL EDUCATION QUALITY ASSURANCE
NONDISTRICT UNIT
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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: _____
(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 | ☐ Visual Impairment |
| ☐ Functional Deafness | ☐ Orthopedic Impairment |
| ☐ Blindness | ☐ Emotional Disturbance |
| ☐ Deaf-Blindness | |

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

- | | |
|--|--|
| ☐ Intellectual Disability | ☐ Hearing Impairment |
| ☐ Autism | ☐ Visual Impairment |
| ☐ Emotional Disturbance | ☐ Orthopedic Impairment |
| ☐ Speech or Language Impairment | ☐ Other Health Impairment |
| ☐ Deafness | ☐ 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: _____