

## 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 <u>Blindness</u>, a minimum of one of the following documents must be submitted:

		Current ophthalmologic examination, <u>administered within the last 12 months;</u> New York State Commission for the Blind and Visually Handicapped (CBVH) report indicating legal Blindness
Fo	r a child	l with <u>Deafness,</u> submit:
		Current audiogram, administered within the last 12 months
3.		the following school/educational information with this application (if available; if your child is currently eschool 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 <u>can</u> 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 <u>one</u> method for submission (e-mail <u>or</u> mail <u>or</u> 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.

October 19, 2015

# 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? $\ \square$ Yes $\ \square$ 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 tex								
9.	. Indicate <b>current</b> 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)								

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10. Indicate child's primary disability ( <i>check only one</i> )											
a.	Primary Disabling Condition (check only one)										
	☐ Deafness	☐ Blindness		☐ Deaf-blindness							
b.	If child has multiple disabilities (check all that apply)										
	☐ Autism			Orthopedic Impairment							
	☐ Emotional Distu	rbance		Other Health Impairment							
	☐ Hearing Impairment			☐ Speech or Language Impairment							
	☐ Intellectual Disability			Traumatic Brain Injury							
	☐ Learning Disabi	lity		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											

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