

ISBVI OUTREACH

Serving . Leading . Empowering

Indiana School for the Blind and VI
5050 E 42nd St.
Indianapolis, IN 46226
317.253.1481, ext. 189 (P)
317.237.1941 (F)

REQUEST FOR ISBVI SERVICES

LOCAL EDUCATIONAL AGENCY: _____

SPECIAL EDUCATION DIRECTOR: _____

AGENCY ADDRESS: _____

AGENCY PHONE/FAX NUMBERS: _____

STUDENT NAME: _____ DATE OF BIRTH: _____

STUDENT'S CURRENT SCHOOL AND SCHOOL ADDRESS: _____

Please indicate the specific ISBVI services you are requesting:

(There is a \$180.00 charge/hour portal to portal for an FVA/FLA, MAT Lab, O&M eval, or observation.) (If requesting two services at the same time, there will only be one \$180.00 charge per hour portal to portal as long as there is only one trip to complete the request.)

LEA – Director of Special Education or Program supervisor (Signature)

Date Signed

Teacher of Students with Visual Impairment (Signature)

Date Signed

Teacher of Students with Visual Impairment Email _____

Parent/Guardian Signature below indicates consent for participation of ISBVI representative(s) in the services specified above and permission for release/exchange of medical and educational information specific to requested services.

Parent/Guardian (Signature)

Date Signed

Parent/Guardian Email Address: _____

Please attach a current copy of the IEP and FVA/FMA.

Date request received _____

Date of contact _____

Date of service _____

Date report completed _____

Date report sent _____