REQUEST FOR HOME/HOSPITAL (H/H) SERVICES 2019-2020 School Year

SECTION 1 THIS SECTION TO BE COMPLETED BY QUALIFIED MEDICAL PRACTITIONER DIAGNOSIS: Disease/Injury/Surgery (primary diagnosis): Drug/Alcohol Treatment Pregnancy Other* (describe): I certify that this student is unable to attend public school for weeks. BUSINESS ADDRESS TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER SIGNATURE DATE CONTACT TELEPHONE NUMBER SECTION 2 THIS SECTION FOR SCHOOL DISTRICT USE If the student is eligible to receive special education services, does the IEP team need to meet? \[Yes \] No CHECK ONE Original Request	SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle)	Please Print
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NOTE: Beginning date on extension request must consecutively follow ending date of original.		Beginning date of	instructional time or extension:	MO DAY YEAR
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SCHOOL DISTRICT AUTHORIZATION

CONTACT TELEPHONE NUMBER