Parent's/Caregiver's Name	
Address	Date
City, State, Zip Code	
School Name	
School Address	
City, State, Zip Code	
DearChild Study Team Member	
I am the parent of	, born on My
Name of Ch	No. of the second secon
child is in theg	rade at Name of School
I believe that my child needs to b	ol district pay for an independent evaluation of my child be independently evaluated by a specialist in by, Occupational Therapy, Psychology, Learning Disabilities)
unless the district requests a due evaluation was appropriate. Plea	quired to provide my requested independent evaluation process hearing within 20 days and proves that their use contact me as soon as possible at my request.
Phone number	
Thank you for your time and assi Very truly yours,	stance in my child's education.
Parent's/Caregiver's Name	
cc:	

ear		
	, born on	My
am the parent of		My
am the parent ofgradhild is in thegradhild is in thegradhild make the school did believe that my child needs to be in		ation of my chi
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