



EDUCATIONAL SERVICES UNIT
 Burlington County Special Services School District
 20 Pioneer Blvd., Westampton, NJ 08060-3824
 www.edservicesunit.com
 (609) 702-0500

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Deaf and Hard of Hearing Child Study Team Evaluation Request Form

Student Name:		School District:
DOB:		NJ SID#:
School Attending:		Classification:
Grade:		Case Manager:
Primary Language of student:		Email:
Home Address:		Phone#:
City, State, Zip:		CST Director:
Guardian Name:		Email:
Guardian Email:		Phone Number:
Home #:	Cell #:	Projected Results Meeting Date:

Required Documents
<p>Important Note: We cannot process an evaluation request without the submission of the following documents:</p> <ul style="list-style-type: none"> ● Evaluation Plan ● Audiogram ● IEP (if applicable)

Services Requested			
Evaluation Type:		Evaluation(s) Requested:	
<input type="checkbox"/>	Initial Evaluation	<input type="checkbox"/>	Learning
<input type="checkbox"/>	Re-Evaluation	<input type="checkbox"/>	Psychological
Evaluators to attend Results Meeting <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	Speech Language <input type="checkbox"/> Plus Articulation

Additional Information Required			
Amplification			
<input type="checkbox"/>	Personal Hearing Aids _____ (Age first aided)	<input type="checkbox"/>	Personal FM System
		<input type="checkbox"/>	Classroom Soundfield System
Cochlear Implant			
<input type="checkbox"/>	Cochlear Implant: <input type="checkbox"/> Right <input type="checkbox"/> Left	Age of Implantation: _____	
Current Support			
<input type="checkbox"/>	Educational Interpreter*	<input type="checkbox"/>	Teacher of the Deaf
		<input type="checkbox"/>	Educational Audiologist
* Our D/HH Child Study Team Educational Interpreter will be present during the observation and testing. We do not provide interpreters for district provided evaluators.			

<p>Notes for the Evaluator:</p>
<p>Please Note: Our evaluation process includes a record review and one formal classroom observation in accordance with NJAC6A:14. If additional observations are desired, please contact our office.</p>

_____ **CST Director Signature** _____ **Date**

Send Completed Request to: ESUDHHCST@burlicoschools.org or Phone #: 609-702-0500 x7409
 If Evaluator(s) requested at results meeting, district will be billed for IEP conference time.