WAYNE COUNTY BOARD OF EDUCATION

SPECIAL EDUCATION DEPARTMENT
212 N. COURT STREET
WAYNE, WV 25570
TELEPHONE: (304) 272-5116 FAX: (304) 272-5993

Physician Report Form

Student:_____ **DOB:**_____

School:_____ **Grade:**_____

Parent/Guardian:_____ **Phone:** _____

Address:_____ **Medicaid #**_____

This student is being evaluated to determine if special education or related services (e.g.504) are necessary. Your assistance in this process is greatly appreciated. Please provide the requested information to assist the Eligibility Committee in making its determination. Attach any pertinent reports, including treatment plans and results of any vision or hearing screenings.

Please state the student's diagnosis and specify educational needs resulting from the condition. We are NOT requesting an evaluation or services to be performed at this time, but reports of diagnostic work performed in the past. Please return to the address/fax listed above.

Diagnosis and summary of condition:

Impact on Education:

Physician Name (please print):_____

Office Address:_____ Phone:_____

Physician Signature:_____ Date:_____