

Ephrata School District 165

REQUEST FOR HOME/HOSPITAL INSTRUCTION

SCHOOL DISTRICT NAME		STUDENT NAME: (Last, First, Middle) <small>Please Print</small>	
CONTACT PERSON	TELEPHONE NUMBER	STUDENT GRADE LEVEL	GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female

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.

_____ <small>TYPE/PRINT NAME OF QUALIFIED MEDICAL PRACTITIONER</small>	BUSINESS ADDRESS _____
_____ <small>SIGNATURE</small>	_____ <small>CONTACT TELEPHONE NUMBER</small>
_____ <small>DATE</small>	

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

Extension

Beginning date of instructional time or extension:

MO	DAY	YEAR
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NOTE: Beginning date on extension request must consecutively follow ending date of original

_____ <small>SCHOOL DISTRICT AUTHORIZATION</small>	_____ <small>DATE</small>	_____ <small>CONTACT TELEPHONE NUMBER</small>
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FORM SPI E-310 (Rev. 8/07)