Visual Impairment Program
Caseload Overview

Teacher: _____ **Office Location:** _____ **School Year:** _____

#	Student's Name	School	Placement	Grade	IEP Due	Evaluation Due	Direct Time	Consult Time	Travel Time
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
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16									
17									
18									