Request for Independent Education Evaluation (IEE) Form

Pursuant to 603 C.M. R. 28.04 (5) and the appropriate Massachusetts Division of Health Care Finance and Policy Regulations 114.3 CMR 30.00 TEAM Evaluation Services

Student: _____ ID# _____ DOB:_____

School: _____

Parent/ Guardian(s) Name: _____

Parent/ Guardian(s) Address: _____

Parent/ Guardian(s) Phone: _____

Provider selected by parent to complete assessment(s):

Provider Contact Name: _____

Facility: _____

Address: _____

Phone#: _____

Date Provider contacted and pertinent student information relayed: _____

Specific Assessment(s) Requested By Parent:

Name of Assessment	**Anticipated Time (hours) to Complete Assessment**
_____	_____
_____	_____
_____	_____

Parent/guardian signature: _____Date: _____

Date received by Special Education Coordinator for processing: _____