

NOTICE OF REQUEST FOR 504 DUE PROCESS HEARING

Information that is requested in all shaded boxes must be provided. This form may be completed by the parent of the child with a disability or, if appropriate, the attorney representing the child. This form needs to be returned to ASD 504 Compliance Coordinator via fax at 742-4289 or ASD Education Center 5530 E. Northern Lights Blvd. 2nd Floor within 1 calendar year of the decision with which the parent disagrees.

1. CHILD		
CHILD'S NAME	CHILD'S ADDRESS	CHILD'S DATE OF BIRTH
SCHOOL OR PROGRAM ATTENDED	SCHOOL / PROGRAM ADDRESS	SCHOOL CONTACT NAME & NUMBER
PARENT OR GUARDIAN	PARENT / GUARDIAN ADDRESS (IF DIFFERENT)	PARENT / GUARDIAN PHONE
ATTORNEY OR LEGAL REPRESENTATIVE	ADDRESS	PHONE / FAX NUMBERS
	MAIL TO: [enter district contact here]	

Parent/Guardian Signature: _____

Date: _____

**2.
PROBLEM**

PARENTS CAN REQUEST A HEARING IF THEY DISAGREE WITH THE IDENTIFICATION, EVALUATION, EDUCATIONAL PLACEMENT OR PROVISION OF A FREE APPROPRIATE PUBLIC EDUCATION (FAPE) TO THEIR CHILD.

DESCRIBE THE PROBLEM WITH YOUR CHILD'S SPECIAL EDUCATION PROGRAM, AND THE SPECIFIC ACTIONS THAT THE SCHOOL DISTRICT HAS TAKEN OR REFUSED TO TAKE. INCLUDE FACTS ABOUT THE PROBLEM.

3. PROPOSED SOLUTION

DESCRIBE WHAT YOU THINK NEEDS TO BE DONE TO SOLVE THE PROBLEM, IF YOU KNOW OR HAVE ANY SPECIFIC IDEAS AT THIS TIME.