



**HOME/HOSPITAL INSTRUCTOR PROGRAM
REQUEST FOR SERVICES**

Home/hospital instruction is provided to students enrolled in a public school who are temporarily unable to attend school for an estimated period of four weeks or more because of physical and/or mental disability or illness.” OSPI Bulletin No. 031-18



REQUEST FOR HOME/HOSPITAL INSTRUCTION

Please Print

This section to be completed by Parent/Guardian

| | | | |
|---|---|---|---------------|
| STUDENT NAME (Last, First, Middle) | <input type="checkbox"/> ... Male <input type="checkbox"/> ... Female <input type="checkbox"/> Optional | G | Contact Phone |
| Is this student enrolled in a Special Education Program? ... Yes ... No | | | |

This section to be completed by Qualified Medical Practitioner

| | | |
|--|--|------|
| <p>DIAGNOSIS:</p> <p>%00 DISEASE/INJURY (specify primary diagnosis) _____</p> <p>%00 DRUG/ALCOHOL TREATMENT _____</p> <p>%00 PREGNANCY _____</p> <p>%00 OTHER* (Specify) _____ *Prior telephone approval required</p> <p>I CERTIFY THAT THIS STUDENT IS UNABLE TO ATTEND PUBLIC SCHOOL FOR _____ WEEKS A minimum of 4 weeks, maximum of 18 weeks, consecutive or intermittent</p> | <p>CODE: (ICD-9-CM)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> | |
| NAME & TITLE of Qualified Medical Practitioner: | SIGNATURE | DATE |

BUSINESS ADDRESS

MAIL TO: 1 Administration #09