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## Eastern Illinois Area of Special Education

5837 Park Drive, Suite 1

Charleston, IL 61920

Phone: (217) 348-7700 - FAX: (217) 348-7704

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### Parent/Guardian Notification of Decision Regarding A Request For An Evaluation

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NAME OF CHILD	DATE OF BIRTH	DATE
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Dear \_\_\_\_\_

A request for a special education evaluation was made for your child on \_\_\_\_\_ by \_\_\_\_\_

\_\_\_\_\_ for the following reasons:

\_\_\_\_\_  
(Name and Title of Person Making Request)

#### Request for Initial Evaluation:

- A review of the request has determined that an initial evaluation **is not appropriate** at this time.
- A review of the request has determined that an initial evaluation **is appropriate** at this time.

#### Request for Reevaluation:

- A review of the request has determined that a reevaluation **is deemed necessary** at this time.
- A review of the request has determined that a reevaluation **is not deemed necessary** at this time.

The reasons and relevant factors for the above indicated decision include:

If an evaluation was deemed appropriate or a reevaluation is necessary to determine a child continues to be a child with a disability, the process will begin upon the receipt of written informed consent from the parent/guardian. You and your child have rights and protections under the procedural safeguards and may wish to review your copy of **Explanation of Procedural Safeguards** regarding the district's decision. To discuss any concerns or if you have any questions regarding this decision, please contact:

- Parent/Guardian provided a copy of the **Explanation of Procedural Safeguards**.

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*Name*

*Title*

*Phone*

Sincerely,

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*Signature*

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*Name and Title*