Section III

Home/Hospital Review Committee

To be completed by the Home/Hospital Instruction Team.

Name of Student: _____

Date Application Received: _____ Approved _____Denied _____Incomplete _____

If approved, date services will be provided from _____until _____
(Review Date)

If eligibility for services denied, reason for denial:

_____

_____

_____

If incomplete application, type of additional information requested

_____

_____

Date of Decision _____ Person Contacted: _____

Signatures of Home/Hospital Instruction Team:

Assistant Superintendent: _____ _____
Date

Home/Hospital Services
Program Director: _____ _____
(Building Principal) Date

Local Medical or
Mental Health Personnel: _____ _____
(School Nurse or Doctor) Date

Comments:

_____

_____

_____

_____