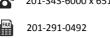




201-343-6000 x 6511







Supervisor - Educational Enterprises

Supervisor - Sound Solutions

LISA STEWART

Please email completed form to: lisstew@bergen.org

TEACHER OF THE DEAF AND HARD OF HEARING SERVICES

AUDITORY VERBAL BASED TECHNIQUES

SEPTEMBER 2018-JUNE 2019

SEPTEMBER 2019-JUNE 2020

SEPTEMBER 2020-JUNE 2021

PLE	ASE COMPLETE ELECTRON	IICALLY OR PR	INT LEGIBLY	
SERVICE INFORMATION (STUDENT SERVICES				
STUDENT'S NAME:		AGE:	DOB:	GRADE:
PARENT'S NAME(S):	PHON	IE:	MAY\	WE CONTACT PARENT(S)? Y N
HOME ADDRESS:				ZIP:
SCHOOL STUDENT ATTENDS:				PHONE:
SCHOOL ADDRESS:				ZIP:
CASE MANAGER NAME(S):				
DIRECTOR OF SPECIAL SERVICES NAME:				
REPORTS WILL BE SENT TO DIRECTOR/ADMIN	NISTRATOR			
•	***MUST PROVIDE CURRENT	AUDIOLOGICAL	REPORT***	
TI	HE FOLLOWING IS A REQUEST	FOR (CHECK ONI	OR MORE)	
TEACHER OF THE DEAF AND HARD OF HEARING				
CONSULTATION TO DETERMINE SERVICES (1-3 HR. M	AX)			
IN-SERVICE/WORKSHOP: "EDUCATION FOR ST	UDENTS WHO ARE DEAF/HARI	O OF HEARING"		
(INCLUDED W/ DIRECT SERVICES OF 2x/wk. OR MC	DRE)			
DIRECT SERVICES (SESSION = 45 MINUTES)	1x/wk. 2x/wk.	3x/wk.	4x/wk.	Other**
AUDITORY VERBAL BASED TECHNIQUES	with LISTENING AND	POKEN LAN	GUAGE SPE	CIALIST
CONSULTATION: 1x/yr. 2x/yr.	☐ 3x/yr. ☐ 4x/yr.	Other**		
DIRECT SERVICE: 1 SESSION/WEEK (45 MI				
***************************************	ession per week will have 2		4	
Sel Aices less man 1 se	ssion per week will have a	i ilours auueu	to contract ic	or service reporting
***CONTRACT INFORMATION – M	UST BE COMPLETED	**C0	NTRACT WIL	L BE SENT TO (ADMINISTRATOR)
FULL NAME:	TITLE			DISTRICT:
ADDRESS:				ZIP:
COUNTY:	PHONE #:			FAX #:
AUTHORIZED BY (SIGNATURE):				DATE:
PLEASE SE	END ANY ADDITIONAL INF	ORMATION O	N A SEPARAT	
				Office Use Only

Initials: _

_ Date: _

_ Assigned: _