

PLEASE READ!

IMPORTANT INSTRUCTIONS FOR COMPLETING THIS FORM.

- 1. DO NOT USE THE RETURN KEY TO MOVE BETWEEN FIELDS. USE TAB KEY ONLY.**
- 2. IF YOU HAVE DIFFICULTY WITH THIS FORM, PRINT OUT THE PDF VERSION AND COMPLETE IT BY HAND.**

Request for HCOE Bus Transportation

TR-11

Name of Pupil: _____ DOB: _____ Grade: _____

If the pupil is 6 years or younger, please indicate the child's weight:

- Initial IEP Annual Triennial Other
 New or Continuing (check one)

District of Residence: _____

School Attending: _____ Teacher: _____

Class Bell Times: _____ To: _____ Start date for transportation (*new student only*) _____

Home Address: _____

Name of Parent/Guardian: _____

A.M. Bus Location: _____ Phone #: _____

P.M. Bus Location: _____ Phone #: _____

Type of Services to be Provided:

- Non-severely handicapped Severely handicapped (*identify condition below*)

Qualifying Conditions fo Severely Handicapped Transportation:

- Autism Blindness Deafness Severe developmental delay
 Serious emotional disturbance Severe orthopedic impairment
 Orthopedic handicap requiring a wheelchair lift

Special Conditions/Considerations/Recommendations/Restrictions:

Reason for request; Change of Address Change of Program

Approved by:

District of Residence: _____ Date: _____

District of Attendance: _____ Date: _____

Original: HCOE Transportation Yellow: District of Attendance Pink: District of Residence