PCPS USE ONLY
DATE RECEIVED: _____
APPROVED: YES_____ NO _____
COMPLETED DATE:
_____

Pulaski County Public Schools
Reach Each Child

Pulaski County Public Schools
202 N. Washington Avenue, Pulaski, Virginia 24301
Phone: 540-994-2545 Fax: 540-994-2560

STUDENT Certification for Need of Homebound Instruction

PART A: STUDENT INFORMATION

DATE OF APPLICATION:	☐ Initial ☐ Extension	School
Name of Student:	**DOB:**	**Grade:**
Name of Parent/Guardian:	**Phone: (____)_____** **Phone: (____)_____**	
Home & Mailing Address:	**Guidance Counselor**	**Ext:**
	Case Manager	**Ext:**
	Homebound Instructor/s	**Phone:**

***Check all that apply*: (Reason homebound is requested)**
☐ **MEDICAL (accompanied by medical documentation)** ☐ **504 (with Documentation)** ☐ **IEP (with IEP/Amendment Documentation)** ☐ **ADMINISTRATIVE (Central Office – accompanied by documentation i.e. letter, etc.)**

SUBJECT	SOL COURSE (Y/N)	*SUBJECT Classroom TEACHER*	Phone/EXTENSION

Initial number of hours approved: _____ Beginning Date: _____Terminating Date:_____

DATES OF EXTENSIONS ☐ *1st Ext.* **Date From: Ending Date:**	**Approval:**
***2nd Ext.* Date From: Ending Date:**	**Approval:**
***3rd Ext.* Date From: Ending Date:**	**Approval:**

IEP or 504 team reconvenes: (date) _____

*Homebound instruction is a temporary instruction plan. This plan will expire in a maximum of 90 calendar days. Any extension of a homebound plan will require updated documentation.**

PART B: Acknowledgment by Parent

I, _____, parent/guardian/student, acknowledge this request and agree with the need for homebound services. I will provide an environment conducive to learning, a responsible adult in the home, keep appointments, keep up with assignments, and advise school personnel of changes in my child's status. I acknowledge if it is necessary for homebound instruction to continue beyond nine weeks, an extension or re-authorization form, including treatment plan, progress towards treatment goals, and specific plans to transition the student back to the school setting, will be required. I also authorize release and exchange of medical information between health care provider and school division.

_____ _____

Date **Signature of Parent/Student (if 18+ yrs old)**

PART C: Completed by Pulaski County Schools Staff

Approved By:_____, Director of Special Education or Designated Representative