**Form A**

Notice of Intention to Seek Review

**NOTICE:**

The undersigned intends to seek review of the determination of the impartial hearing officer concerning the identification, evaluation, educational placement, or manifestation determination of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(*name of student with a disability*)

The school district is required to prepare and submit a certified copy of the hearing record to the Office of State Review in accordance with section 279.9 of the regulations of the Commissioner of Education. If you wish to seek review of this determination as well, you must send to the party listed below a notice of intention to cross-appeal in accordance with Part 279 of the Regulations of the Commissioner of Education, within 30 days after the date of the decision of the impartial hearing officer. You may find this form on the website of the Office of State Review (**www.sro.nysed.gov**).

**Case Information Statement**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of the party filing this notice Date*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of the other party (school district or student) involved in this matter*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Date of Impartial Hearing Officer Decision Impartial Hearing Officer Case Number*

**Issues for Review:** Please check the boxes that best apply to the issues you intend to ask a State Review Officer to address (check all that apply).

⬜ IDEA Eligibility ⬜ Child Find ⬜ CSE Meeting Process

⬜ Required Notices ⬜ Evaluative Information ⬜ Present Levels of Performance

⬜ Annual Goals ⬜ Educational Placement ⬜ Least Restrictive Environment

⬜ Related Services ⬜ Transition Services ⬜ 12-Month (ESY) Services

⬜ Unilateral Placement ⬜ Equitable Considerations ⬜ Relief Requested

⬜ Independent Evaluation ⬜ Pendency (stay-put) ⬜ IEP Implementation

⬜ Prior Written Notice

⬜ Other (Please Specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Signature*) (*Your Printed Name*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Your Street Address*) (*Your City and Zip Code*)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*Your Telephone Number*) (*Your Fax Number or Email Address*)