Ingham Intermediate School District
Special Education

Physical Impairment (R340.1709)
Eligibility Recommendation

Student Name: _____ Report Date: _____
Birth Date: _____ Grade: _____ School Building: _____
School District: _____ Parent/Guardian: _____

PURPOSE

This form will be used by the Evaluation Team to recommend: (Choose one)

☐ **Initial eligibility** for special education.
(Behind this page attach a copy of all referenced documents and a copy of the Consent for Initial Evaluation)

☐ **Redetermination of eligibility** for special education.
(Behind this page attach a copy of all referenced documents and the REED)

EVALUATION SUMMARY
Include enough detail to determine a starting point for instruction

Area of Evaluation	Data Source	Performance Level	Name/Date of Attached Report/Document

- Medical Information

- Educational Performance

- Achievement Level

- Information from Parents

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Student Name: **Error! Reference source not found.** DOB: **Error! Reference source not found.** Date: **Error! Reference source not found.**

DIAGNOSTIC ASSURANCE AND DOCUMENTATION

*Physician Statement received ☐ No ☐ Yes, Date _____

The Evaluation Team must consider the following assurance statements before making a recommendation regarding this student's eligibility:

- This student manifests impairment with all of the following behavioral characteristics:
  - A severe orthopedic impairment that adversely affects his/her education performance ☐ Yes ☐ No
  - This student requires special education programs/services ☐ Yes ☐ No

EXCLUSIONARY CONSIDERATIONS

- Was the determinant factor for eligibility a result of:
  - Lack of instruction in reading and math? ☐ Yes ☐ No
  - Limited English proficiency? ☐ Yes ☐ No

ELIGIBILITY RECOMMENDATION

The Evaluation Team 1) finds all of the diagnostic assurance statements to be true and 2) recommends, based on the evaluation findings, that this student be determined eligible for special education programs/services under the Physical Impairment Rule (R340.1709). ☐ Yes ☐ No

PARTICIPANT SIGNATURES

As a member of the Evaluation Team, my input is included in writing and I agree with the eligibility recommendation: (Sign and check below. Attach more complete statement if an Evaluation Team member checks no).

	Yes	No		Yes	No
**Other/Role _____	☐	☐	Other/Role _____	☐	☐
Other/Role _____	☐	☐	Other/Role _____	☐	☐
Other/Role _____	☐	☐	Other Role _____	☐	☐

**At a minimum, there must be two Evaluation Team members, either an orthopedic surgeon, internist, neurologist, pediatrician, family physician or any other approved physician as defined in Act No. 368 of the Public Acts of 1978, as amended, being 333.1101 et seq. of the Michigan Compiled Laws and another person who is responsible for evaluating students suspected of being handicapped or handicapped person being reevaluated.

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