**Application for Home Teaching (HT) Services**

**Please consult the** [**Guidelines for Home Teaching Services**](https://www.gov.nl.ca/education/files/k12_studentsupportservices_ht_guidelines_oct2015.doc)

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| Student Name: Click here to enter text.  | Date of Birth: Click here to enter a date.  |
| Grade: Click here to enter text. | Region/District: Choose an item. |
| School Name:Click here to enter text. | Period of absence from school: Choose an item.If you selected ‘Other’ please explain:Click here to enter text. |
| Reason for absence: [ ] Accessibility[ ] Social-Emotional/Behavioural[ ] Medical[ ] OtherIf you selected ‘Other’ please explain:Click here to enter text. |
| Is this student availing of courses through CDLI? Choose an item.[ ]  Yes List the course(s). Click here to enter text.[ ]  No If this student is registered in a Level I, II, or III course please explain why they are not availing of CDLI. Click here to enter text. |
| Please indicate that the following criteria have been met: [x]  The student is unable to attend school for a minimum of 1 month or can attend school less than the equivalent of 2 days/week, for at least 2 months.[ ]  The student is enrolled in and is attempting to continue work on courses they are unable to access through CDLI.[ ]  The student is not confined to a hospital during this timeframe.[ ]  The student is not being Home Schooled.[ ]  A medical note is attached which specifies the reason for, and the timeframe of, the absence. [ ]  Arrangements have been made for schoolwork to be provided to the student during this period.[ ]  Arrangements have been made to evaluate the effectiveness of Home Teaching Services and other services being provided.Comments/Additional Information:Click here to enter text. |
| List the specific course name(s) for which HT Services are being requested: Click here to enter text. |
| Total number of hours being requested (to a maximum of 10 hours/month and a yearly total of 30 hours): Choose an item.If you selected ‘Other’ please explain:Click here to enter text. |
| Number of months HT services will be required (to a maximum of 5 months): Choose an item. |
| Type of application (select one):[ ]  New – If this is a **New** application, complete **Section A**: **New Applications**[ ]  Extension – If this is an application for **Extension**, complete **Section B: Extensions** |
| **Section A: New Applications****To be completed by School Administrator and submitted to District Student Services personnel.**This application meets eligibility requirements, as outlined above.**Parent/Guardian Signature: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administrator Signature: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administrator Email address:** Click here to enter text. |
| **To be completed by District Student Services Personnel and submitted to Department of Education Student Services Personnel.  Please choose one.**[ ]  I have reviewed this application, confirm it is complete and meets eligibility guidelines and I support this application. [ ]  I have reviewed this application, confirm it is complete but does not meet eligibility guidelines and I support this application.[ ]  I have reviewed this application and am unable to support it at this time. **Comments/Additional Information:**Click here to enter text.I verify that a medical note is attached to this application.**District Reviewer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_ **Position:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**District Reviewer Email:** Click here to enter text.**Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **For EDU Use:** **Date Reviewed:** Click here to enter a date.**EDU Reviewer:** Click here to enter text.[ ]  **Approved** [ ]  **Not Approved**[ ]  **Requires Additional Information****Approval Start Date:** Click here to enter a date.**Approval End Date:** Click here to enter a date.**Comments: Click here to enter text.** |

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| **Section B: Extensions****To be completed by School Administrator and submitted to District Student Services personnel.**Number of HT hours used to date during this school year: Choose an item.If you selected ‘Other’ please explain: Click or tap here to enter text.Please explain the measures the school has put in place to support the student during their absence: Click here to enter text.What is the expected date for the student’s return to school? Click here to enter a date.What is the detailed plan for the student’s transition back to school? Click or tap here to enter text.Additional information to support this request: Click here to enter text.**Parent/Guardian Signature: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administrator Signature: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Administrator Email address:** Click here to enter text. |
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