THE SCHOOL DISTRICT OF PHILADELPHIA
OFFICE OF SPECIALIZED INSTRUCTIONAL SERVICES
EDUCATION CENTER*
440 North Broad Street – 2nd Floor
Philadelphia, Pennsylvania 19130

TELEPHONE (215) 400-4170 FAX (215) 400-4172

Date

Name & Address

Dear_____:

The Office of Specialized Instructional Services of the School District of Philadelphia has received your request to have your child, (Students Name), evaluated by an independent provider. This letter serves to document the District's approval for an evaluation of the following type:

___ Psychological
___ Psychiatric
___ Neuropsychological
___ Other _____

Enclosed is a list of providers who meet the District's criteria. If you do not select an identified provider, you need to ensure that the provider you select meets District criteria.

If you are seeking an independent psychological evaluation, the provider must be a certified school psychologist. If you are seeking a neuropsychological evaluation, the provider must be a licensed clinical psychologist with appropriate certification in neuropsychology. If you are seeking a psychiatric evaluation, the provider must be a licensed psychiatrist. If you are seeking a different type of independent evaluation, please contact me at (Regional Office #) for more information on the criteria for selecting your clinician.

Once the evaluation is completed, the provider should send a copy of the evaluation report, along with his/her invoice, to my attention at the address listed above. It is the responsibility of the Office of Specialized Instructional Services to ensure that providers on the list understand the District's requirements for invoicing and provide us with a copy of the report. Please do not hesitate to contact me if you have any questions.

Sincerely,

Director of Special Education

Cc: Principal

* Translated versions of this document are available at: www.philasd.org/offices/translation.