School District 43 (Coquitlam) Learning Services

Application for Special Education Assistant Consultation Hours

(Copies must be done in orange-coloured paper)

Date of Application: _____

School Name: _____

Date of Activity/Meeting Requiring Consultation Hours: _____

Name/s of Special Education Assistant/s: _____

_____

Student/s Name/s Related to Request: _____

_____

Name and Position of Person Making Application: _____

_____

Number of Hours Required: _____ **Specific Time Period:** _____
(e.g. 3:30 – 5:00 p.m.)

Reason for Request of Hour/s: _____

_____

_____

Signature of Principal:

_____

*Please note, you will be notified as soon as possible re this request. Upon approval, the individual school must follow the required Personnel procedures involving CADS. The school contact will receive a copy of this slip by fax.

FOR OFFICE USE ONLY:
Request Approved _____ **Request Not Approved** _____

Number of Hours _____

Signature of Zone Coordinator (&/or Elaine Boisson or Dave Taylor)

_____

Last revised: December 2016