INDIVIDUALIZED FAMILY SERVICE PLAN MEETING ATTENDANCE WAIVER FOR AUDIOLOGISTS

Please print or type the following information:

Audiologist Name: _____

Agency, if applicable: _____

Child's Name: _____
Last Name First Name Middle Initial

CBO/EI #: _____ Child's Date of Birth: _____
(Month/Date/Year)

I understand that by completing and signing this form I am certifying that the test results of the audiological evaluation that I completed were obtained within the normal range in at least one/both ears and that I have chosen not to attend the initial Individualized Family Service Plan (IFSP) Meeting for this child.

I also certify that I have submitted my evaluation report on the statewide evaluation format within the required timeframe (within 14 days of receipt of the request to perform the Evaluation/Assessment) to the Child and Family Connections office that is responsible for ensuring that this child receives all Early Intervention services that may be identified as a need.

AUDIOLOGIST CERTIFICATION

I certify this information is correct to the best of my knowledge.

AUDIOLOGIST SIGNATURE _____

DATE SIGNED _____

Under the provisions of the Illinois Mental Health and Developmental Disabilities Confidentiality Act, the Family Educational Rights and Privacy Act, 20 USC 1232g, and the Health Insurance Portability and Accountability Act of 1996, information collected hereunder may not be redisclosed unless the person who consented to this disclosure specifically consents to such redisclosure or the redisclosure is allowed by law.