CCPS APPLICATION FOR SEAC MEMBERSHIP

Name: _____ Date of Application: _____

Address: _____

_____

Home Phone: _____ E-mail: _____

Work Phone: _____ Cell Phone: _____

Are you a (check all that apply)

- ☐ Parent
- ☐ Person with a disability
- ☐ Grandparent
- ☐ Guardian
- ☐ Foster parent of a child/youth with a disability
- ☐ Teacher
- ☐ Representative of a community agency (Please specify)_____
- ☐ Representative of a business or association in the community (Please specify)

_____

- ☐ Other (Please specify) _____

If you are a parent or family member, what is your child's

Age? _____ Grade/Teacher?_____

Disability?_____

What do you hope to accomplish from your participation on the SEAC?

_____

_____

_____

What unique experiences, perspectives, talents or skills could you bring to the SEAC?

_____

_____

If invited to serve on the SEAC, what do you see as needs in special education? (List system-wide issues rather than personal issues.)

_____

_____

Send completed application to:

Dr. Suzan Denby
Supervisor of Exceptional Education
10049 Courthouse Rd. Charles City VA 23030
sdenby@ccps.net