INDEPENDENT EDUCATIONAL EVALUATION (IEE)
Request for Payment

Student: _____ Parent(s): _____
Date of Birth: _____ Parent Address: _____
Grade: _____ _____
School: _____ Phone: _____

Date:	Time	Purpose/Procedure/Item:	Unit Cost*:
	(Fifteen Minute Units*):		

*The examiner shall contact the Director of Pupil Services & Special Education prior to beginning the evaluation for the purpose of determining the unit cost for the IEE. Unit rates are subject to training and experiences consistent District personnel practices. The examiner shall submit transcripts, certification, and experience verification to the Director of Pupil Services & Special Education. All unit cost will be pro-rated by administrators per District wage agreements and schedules. Failure to submit qualification documentation will be sufficient reason for the District to reject the examiner as a qualified examiner to conduct and IEE at public expense.

The D. C. Everest Area School District reserves the right to investigate an examiner, IEE and/or claim prior to making payment.

I verify the above factual information (date, time, item and unit cost).

Provider Signature _____ Parent Signature _____

Date _____ Date _____

Exhibit Adopted: 1/25/00
Exhibit Revised:
RWD:ems

BOARD OF EDUCATION
D.C. Everest Area School District
6300 Alderson Street
Weston WI 54476