

## Technical Assistance/Consultation Request

Florida Diagnostic and Learning Resource System  
6271 St. Augustine Rd., Suite 1 \* Jacksonville, FL 32217  
Phone (904) 633-0770 \* Fax (904) 633-0751

Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

Requestor (name & title): \_\_\_\_\_

School/Agency: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Request for: \_\_\_\_ Technical \_\_\_\_ Consultation

Technical Assistance Needed (define): \_\_\_\_\_

\_\_\_\_\_

\*or\*

Specific Issue for Consultation (define): \_\_\_\_\_

\_\_\_\_\_

Requested Location for Assistance: \_\_\_\_\_

\_\_\_\_\_

Requested Dates (please provide three options):

1) \_\_\_\_/\_\_\_\_/\_\_\_\_ 2) \_\_\_\_/\_\_\_\_/\_\_\_\_ 3) \_\_\_\_/\_\_\_\_/\_\_\_\_

If for specific child, is child registered with UF Jax CARD? \_\_\_\_Yes \_\_\_\_ No

Is there a release of information form completed by parent? \_\_\_\_Yes \_\_\_\_ No

Name and Title of Administrator: \_\_\_\_\_

Signature of the Administrator (**required**): \_\_\_\_\_

### **To be completed by FDLRS Staff:**

FDLRS Staff Member receiving request: \_\_\_\_\_

Assigned to: \_\_\_\_\_

Signature of Asst. Director: \_\_\_\_\_

Signature of Presenter: \_\_\_\_\_

Date Decided: \_\_\_\_\_

*Fax this completed form and the signed parental consent for (if for a specific child) to our office, Attn: Autumn Mauch. A staff member will then contact you to discuss your request. Thank you.*