

Warren County Special Services School District
1500 Route 57, Suite 1
Washington, NJ 07882
Tel. 908-835-1004 Fax 908-835-1042

NOTIFICATION OF IEP MEETING TO DISTRICT OFFICE

NAME OF STUDENT: _____

DATE OF MEETING: ____/____/____ TIME OF MEETING: _____

LOCATION OF MEETING: _____

Name of Therapist	Therapist Notified	
O.T. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
P.T. _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Speech _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Counselor _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SPECIAL NOTES: _____

This form must be completed and submitted to the District Office at least two weeks prior to the scheduled IEP meeting in order that all related services provided may be notified in a timely fashion.