CONNECTICUT STATE DEPARTMENT OF EDUCATION BUREAU OF SPECIAL EDUCATION DUE PROCESS UNIT P. O. Box 2219-Room 364 Hartford, Connecticut 06145-2219 FAX# (860) 713-7153

Request For Mediation

	1)	Name of student)	(Date of birth)	
		who is currently wi	thin the jurisdiction of the	
(Address of res	idence of student)			
	and a	attends		
(School district)		(Name of the school the student attends)		
Parent Signature	Date	District Signature	Date	
Parent Name		District Telephone #	Fax #	
Parent Telephone #	– Fax #	Parent E-mail	Disability category	
The date of the IEP mee	ting at which the parti	ies failed to reach agreement.		
The date of the IEP mee	eting at which the parti	ies failed to reach agreement:		
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	C 1	ies failed to reach agreement: <u>-</u> ute, including related facts:		
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Please forward to the above address and, as appropriate, the parents or the school district.