Mail white and yellow copies to LESA. Retain pink copy for CA-60.

Livingston Educational Service Agency
1425 West Grand River Avenue
Howell, Michigan 48843
Phone: (517) 546-5550 Fax: (517) 546-9538

SE-09.1
Rev. 1/02

Homebound/Hospitalized Referral

Date _____
School _____
District _____

Name of Person Being Referred _____

Handicapped (as determined on IEP) _____ Suspension/Expulsion _____

Date of Birth _____ Sex _____

Address _____

_____ Phone _____

Name of Parent/Guardian _____

Address, if different from above _____

Name of School _____

Schedule: **Time** **Subject** **Teacher**

_____

_____

_____

_____

_____

_____

Name of Referring Person _____

Description of Illness _____

_____

Projected Time of Absence _____

Date of Referral _____

Local District Approval (Signature and Title):

_____

(Required before service can be provided)

When completed, please mail to:

Secretary, Assistant Superintendent for Human Resources
Livingston Educational Service Agency
1425 West Grand River Avenue
Howell, Michigan 48843

Date Physician's Statement Received _____

LESA Approval _____