

**REQUEST FOR HEARING**

**TO:** Director, Office of Special Education  
Arkansas Department of Education

**FROM:** Public Agency Representative or Attorney Representing the Public Agency

**DATE:**

**SUBJECT:** Request for a Due Process Hearing

Because agreement cannot be reached about the identification, evaluation, or educational placement of, or the provision of a free, appropriate public education to \_\_\_\_\_  
(Name of Child)

a due process hearing is requested.

\_\_\_\_\_ Date: \_\_\_\_\_  
(Signature of Public Agency Official or Representative of the Public Agency)

Do you wish to participate in the mediation process?  Yes  No

**Superintendent:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Special Education Supervisor:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**\*Legal or Other Representative:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**\* ATTACH AUTHORIZATION FOR REPRESENTATIVE**

(OVER)

**NOTICE OF HEARING REQUEST**

The Individuals with Disabilities Education Act (IDEA) requires that the information requested below be provided upon request for a due process hearing. This information is submitted by the public agency or the attorney representing the public agency and must be submitted to the Director, Office of Special Education, 1401 W. Capitol, Suite 450, Little Rock, Arkansas, 72201.

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(Name of Child and Date of Birth)

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(Name of Parent)

(Home Phone)

(Work Phone)

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(Address of the Residence of the Child)

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(Address of the Parent if Different From Child's Address)

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[Name of Public Agency (School District) Child Attends]

A description of the nature of the problem of the child relating to the proposed initiation or change, including facts relating to the problem:

A proposed resolution of the problem to the extent known and available to the parents at the time:

**ATTACH EXTRA PAGES IF NECESSARY**