**FORM G Clare-Gladwin Regional Education Service District**

**SECTION 504 – COVER LETTER TO PHYSICIAN**

mm/dd/yyyy

Physician’s Name Medical Facility/Practice Name Physician’s Address Physician City, State, Zip

Re: Student’s Full Name and Date of Birth

Dear Physician’s Name

The above-named student is currently being evaluated by the Clare-Gladwin Regional Education Service District for the purpose of determining the student’s eligibility for services under Section 504 of the Rehabilitation Act of 1973. In order to be eligible under Section 504, the student must have a physical or mental impairment that substantially limits a major life activity.

Enclosed is an authorization for release of information to the School District signed by the student’s parent/guardian. Please assist us with our evaluation by completing and returning the enclosed Physician’s Statement no later than Date by which the SD requires the information followed by.

Please send to:

504 Coordinator Name 504 Coordinator Title 504 Coordinator Street Address 504 Coordinator City, State, Zip 504 Coordinator Phone

We appreciate your assistance in this evaluation process. Please contact me if you have any questions. Thank you in advance for your cooperation.

Sincerely,

504 Coordinator Name 504 Coordinator Phone

c: Enclosures – Physician’s Statement Enclosures – Authorization for Release of Information