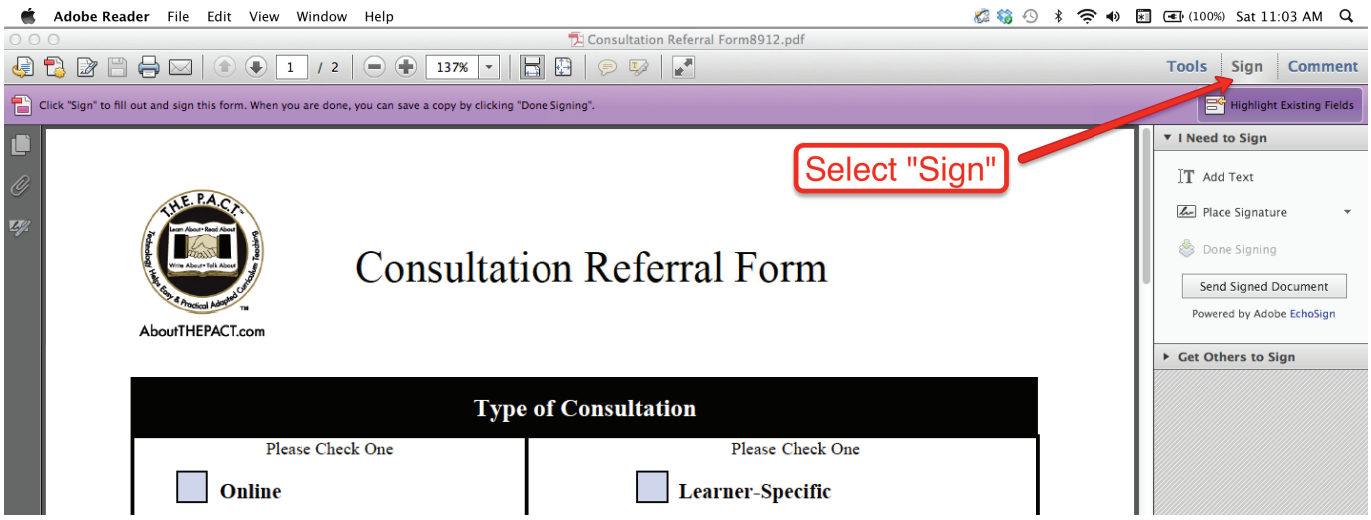
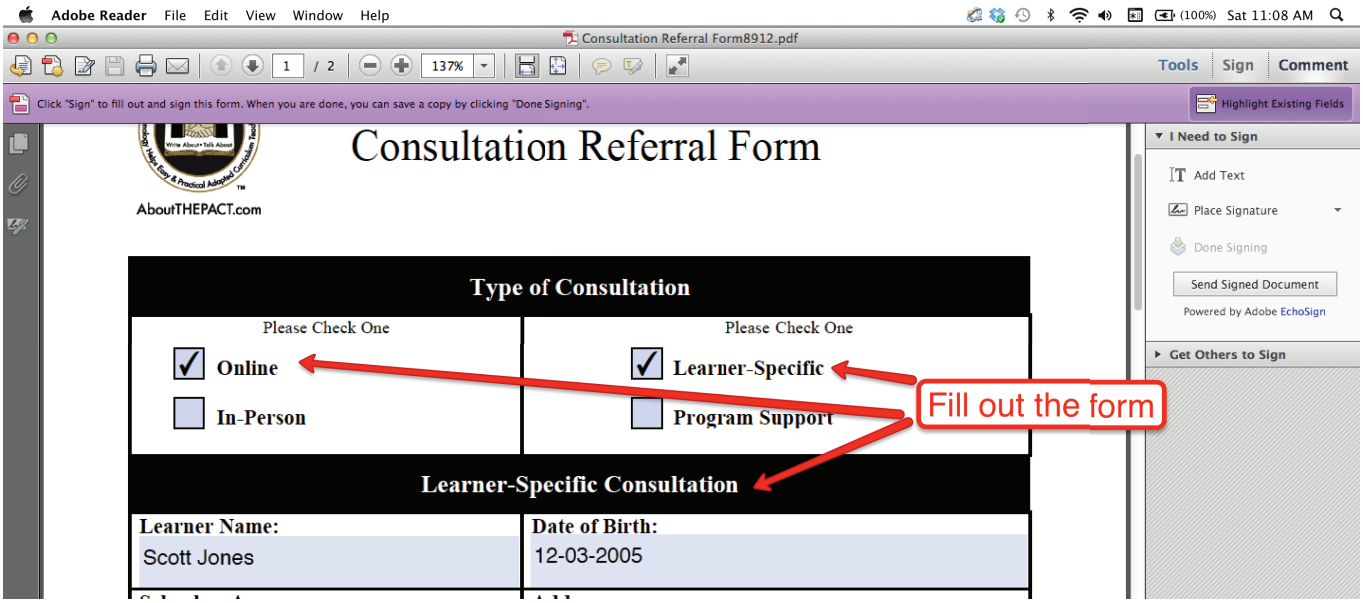
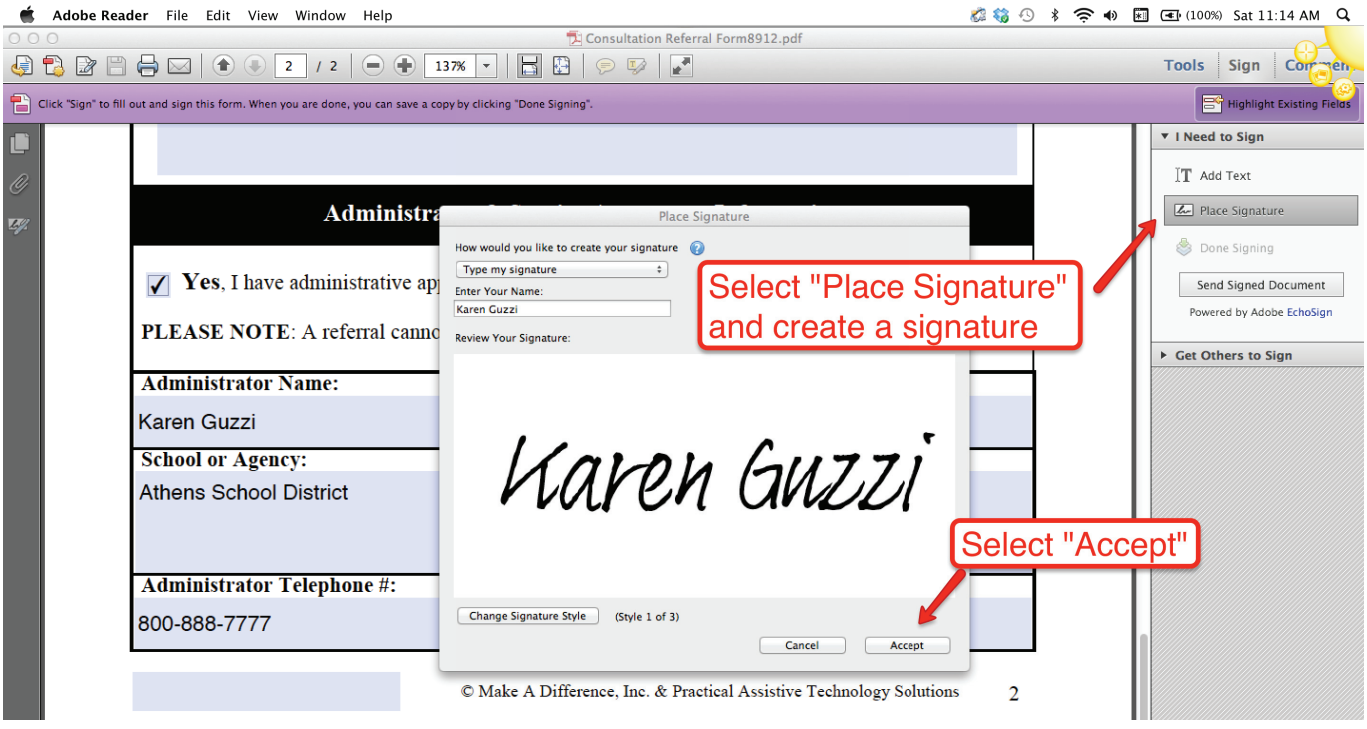
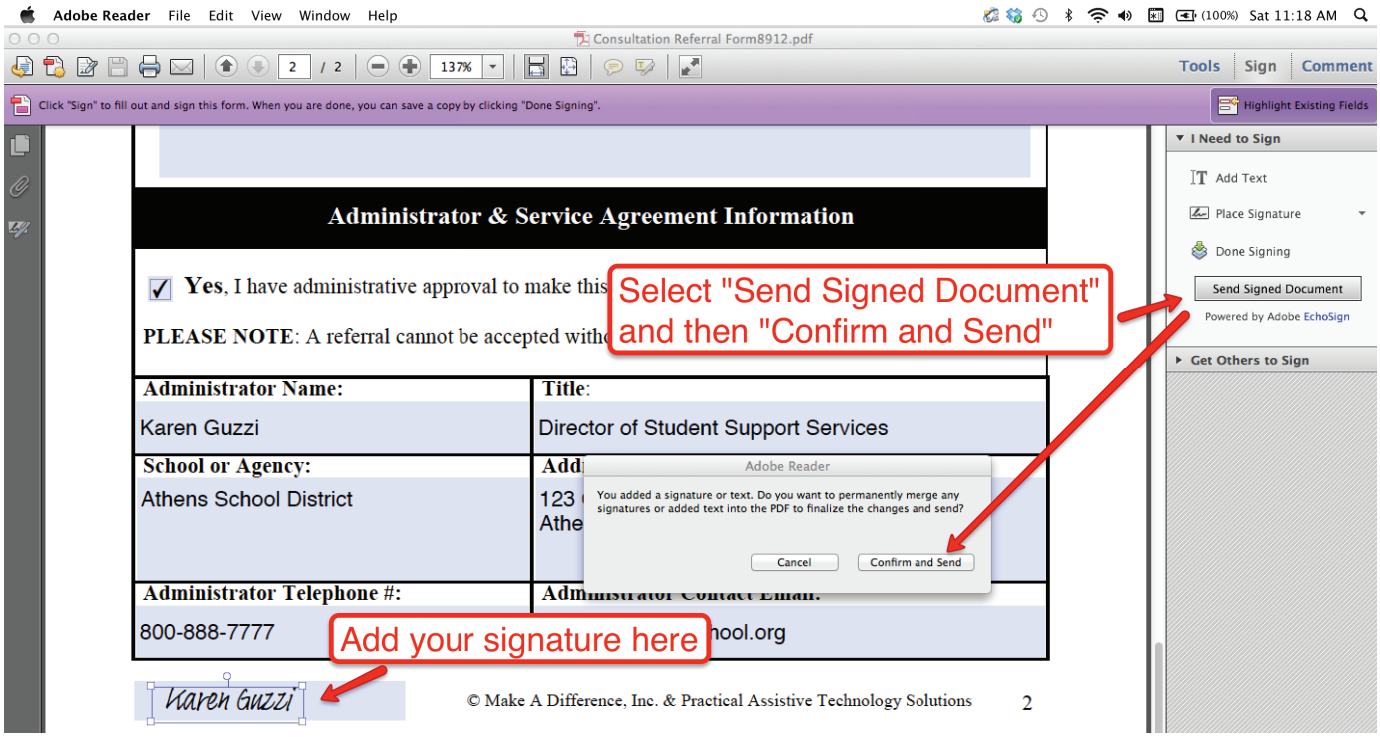
Basic Directions: This form can be digitally filled out and emailed or simply printed and faxed to (802) 484-5558. To digitally fill out the form:





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Sat 11:18 AM
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Tools Sign Comment
Click "Sign" to fill out and sign this form. When you are done, you can save a copy by clicking "Done Signing".
Highlight Existing Fields
I Need to Sign
Add Text
Place Signature
Done Signing
Send Signed Document
Powered by Adobe EchoSign
Get Others to Sign
Administrator & Service Agreement Information
Yes, I have administrative approval to make this
PLEASE NOTE: A referral cannot be accepted with
Administrator Name:
Karen Guzzi
Title:
Director of Student Support Services
School or Agency:
Athens School District
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You added a signature or text. Do you want to permanently merge any signatures or added text into the PDF to finalize the changes and send?
Cancel
Confirm and Send
Administrator Telephone #:
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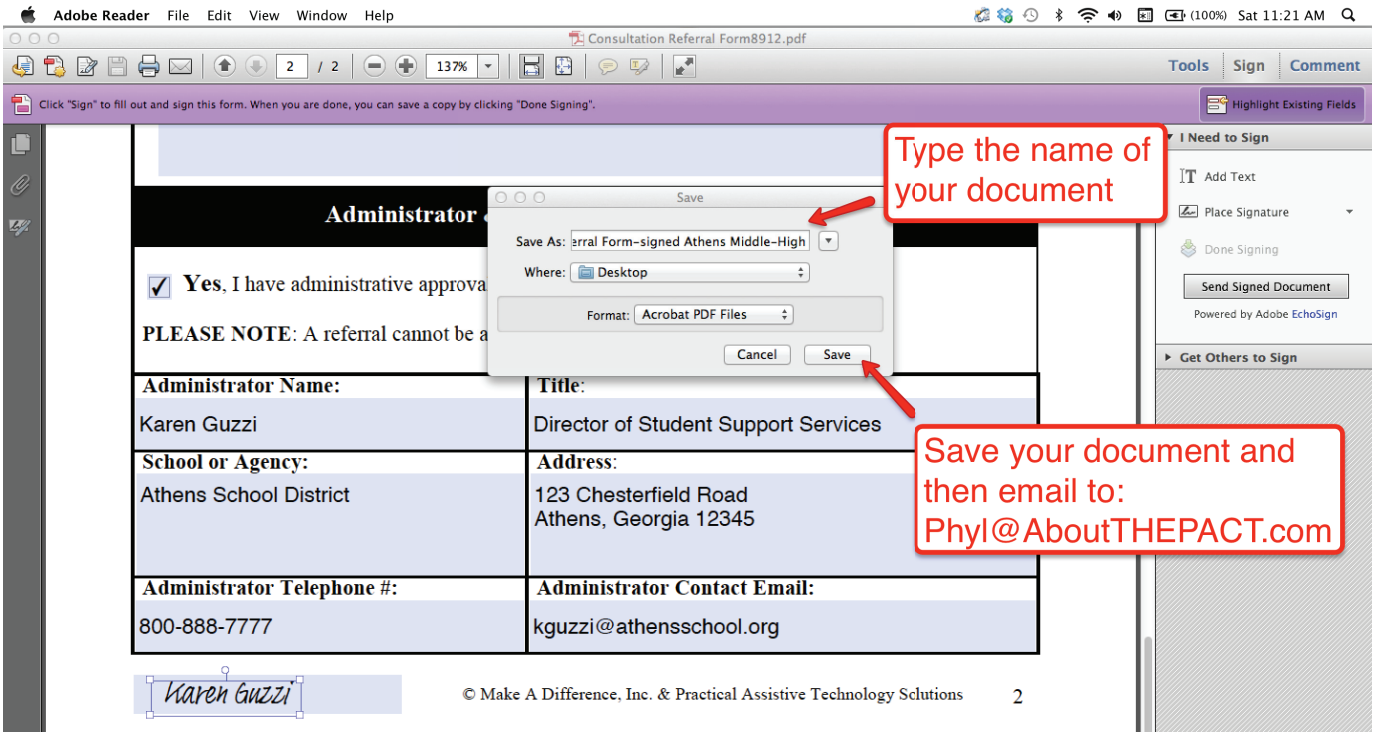
2
Select "Send Signed Document" and then "Confirm and Send"
Add your signature here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Tools Sign Comment
Click "Sign" to fill out and sign this form. When you are done, you can save a copy by clicking "Done Signing".
Highlight Existing Fields
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Where: Desktop
Format: Acrobat PDF Files
Cancel
Save
Administrator Name:
Karen Guzzi
Title:
Director of Student Support Services
School or Agency:
Athens School District
Address:
123 Chesterfield Road
Athens, Georgia 12345
Administrator Telephone #:
800-888-7777
Administrator Contact Email:
kguzzi@athensschool.org
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2
Type the name of your document
Save your document and then email to: Phyl@AboutTHEPACT.com

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Consultation Referral Form

Type of Consultation	
Please Check One	Please Check One
☐ **Online**	☐ **Learner-Specific**
☐ **In-Person**	☐ **Program Support**

Learner-Specific Consultation	
Learner Name:	**Date of Birth:**
School or Agency:	**Address**:
Referral Contact Name:	**Referral Contact Email:**

☐ **Yes**, I can release the learner's records for consultation review.

☐ **Yes**, I can release video clips of the learner for video analysis.

Program Support Consultation	
School or Agency:	**Address**:
Program Name:	
Referral Contact Name:	**Referral Contact Email:**
Program Telephone #:	**Age Range Served:**

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Consultation Referral Form

Consultation Package

Please Check One	Please Check One
☐ **Quarterly Model (Online Only)**	☐ **Up to 2.5 Hours Per Consult**
☐ **Monthly Model**	☐ **Up to 5.0 Hours Per Consult**

Areas of Consultation

Please Check Each of the Following That Is an Area of Need

☐ Initial Setup of T.H.E. P.A.C.T.™

☐ Systematic Curriculum Planning

☐ Expansion of T.H.E. P.A.C.T.™

☐ I.E.P. Development & Improvement

☐ Customization of Instructional Tools

☐ Identification of Communication Tools

OTHER:

Administrator & Service Agreement Information

☐ **Yes**, I have administrative approval to make this referral.

PLEASE NOTE: A referral cannot be accepted without administrative approval.

Administrator Name:	**Title**:
School or Agency:	**Address**:
Administrator Telephone #:	**Administrator Contact Email:**

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