



## Annual EEOP Review

Name \_\_\_\_\_ Student ID# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_ Disability \_\_\_\_\_

Disability Category: (Check at least 1, See Section 504 Reporting Categories)

- Autism     Brain injury impairment     Hearing impairment     Learning impairment
- Major bodily function impairment     Medical impairment     Mental health impairment
- Orthopedic impairment     Other impairment: \_\_\_\_\_

\_\_\_\_\_ Discontinue services. The student no longer needs the 504 accommodations.

\_\_\_\_\_ 504 Team recommends no changes to the EEOP. All current accommodations will remain in place for the coming year. Please attach a copy of the original EEOP. If staffing and/or financial resources are necessary please complete the funding section on the second page and submit for approval.

**Use the following section to document annual review decisions to add or delete EEOP accommodations. If adding an accommodation be sure to note in the narrative who is responsible for implementing any necessary actions.**

EEOP Changes: \_\_\_\_\_ addition \_\_\_\_\_ deletion  
(Use a separate page if necessary and attach to this document)

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EEOP Change: \_\_\_\_\_ addition \_\_\_\_\_ deletion  
(Use a separate page if necessary and attach to this document)

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EEOP Change: \_\_\_\_\_ addition \_\_\_\_\_ deletion  
(Use a separate page if necessary and attach to this document)

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I acknowledge that I have received the service plan designate by the 504 Committee for the student named above.

I also acknowledge that:

1. I am required to implement this plan for this student
2. I understand how to implement the plan; and
3. I can contact the 504 Coordinator if I need further clarification or training.

Team Signatures/Title	Date	Area(s) of Expertise
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

**I participated in the review of this accommodation plan, give consent for it's implementation and have received a copy of the Notice of Parent Rights.**

\_\_\_\_\_ /\_\_\_\_/\_\_\_\_  
Parent Signature Date

**Please outline and estimate the staffing and/or financial resources you are requesting.**

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**Please send a copy of this completed form to the District 504 Director, Douglas Finch**

District Director \_\_\_\_\_ /\_\_\_\_/\_\_\_\_

Original: 504 Folder

Copy: Parent/Guardian