

**APPENDIX B – SAMPLE PARTICIPATION FORM**

North Dakota Department of Public Instruction

# ***Supplemental Services Participation Form***

**\*\*\*This form MUST be returned to the school By:\_\_\_\_\_\*\*\***

Parent Name:	Student(s) Name:
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Please review the enclosed brochure that provides a brief overview of the supplemental services provision. Please note the list of North Dakota-approved providers.

Remember that participation is required. If your child does not attend the assigned services, you will forfeit his/her eligibility and services will be offered to another interested family.

**Check one:**

- Yes, I am interested in enrolling my child to receive supplemental education services. Please send me more information.
- No, I am not interested in receiving supplemental services for my child.

If you checked “Yes” and your child is identified as eligible, you will receive more detailed information on North Dakota’s State-Approved Supplemental Service Providers.

**Check one:**

Would you like the school to contact you to assist you in choosing a provider?

- Yes. Please contact me at the telephone number listed below.
- No. I plan to choose a provider on my own.

Signature of Parent/Guardian:		
Address:	City:	State:
Telephone:	E-mail:	

**APPENDIX B – SAMPLE PROVIDER SELECTION FORM**

**Retrieved from the Iowa Department of Education**

**Supplemental Educational Services  
Provider Selection Form**

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

School: \_\_\_\_\_ Academic Year: \_\_\_\_\_

Check the box that applies:

- My son/daughter **WILL** participate in the Supplemental Educational Services program as it is described in *No Child Left Behind*.
  - ✓ I am selecting the state-approved provider from the list provided to me.
  - ✓ **(1<sup>st</sup> choice)** I select \_\_\_\_\_
  - ✓ **(2<sup>nd</sup> choice)** I select \_\_\_\_\_
  - ✓ I understand that the provider will regularly inform me and my child's teacher(s) of his/her progress.
  - ✓ I understand that if funds are insufficient to cover the supplemental educational services for all of the students who choose to participate, participation will be based on prioritized academic need as defined by the district.
  
- My son/daughter **WILL NOT** participate this academic year in the Supplemental Educational Services program as it is described in the *No Child Left Behind Act of 2001*.

\_\_\_\_\_  
Signature of Parent/Guardian Date

\_\_\_\_\_  
Printed Name of Parent/Guardian Daytime Telephone Number

\_\_\_\_\_  
Evening Telephone Number

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**Office Use Only**

Date Received: \_\_\_\_\_

SES Provider: \_\_\_\_\_