

ST. CLOUD AREA SCHOOL DISTRICT 742

**APPLICATION FOR SERVICE ON
SPECIAL EDUCATION ADVISORY COMMITTEE**

All information on this form is available to the general public upon request

Applicant Name: _____
(First Name) (Last Name)

Applicant Address: _____
(Street) (City) (State)
(Zip)

Daytime Phone: _____ **E-Mail:** _____

Evening Phone: _____

STATISTICAL INFORMATION

The following information is optional and is sought for the purpose of compiling the annual report on the appointments.

Gender: _____ Female
 _____ Male

Disabled: _____ Yes
 _____ No

National Origin: _____ African American
 _____ American Indian
 _____ Asian/Pacific
 _____ Caucasian
 _____ Hispanic
 _____ Other _____

STATEMENT OF QUALIFICATION/INTEREST

(May continue on the back or on attached sheet)

(Signature of Applicant) (Date)

If applicant is being nominated by another person or group, signature indicates consent to nomination. You will not receive an acknowledgment of this application but the appointing authority will notify you if an interview is desired.

MAIL THIS COMPLETED APPLICATION TO: Director of Special Education
District Administration Office
628 Roosevelt Road
St. Cloud, MN 56301

SUBMIT IN PERSON: Room 114, District Administration Office
OR BY FAX: 320-240-8455
PHONE: 320-202-6800

On request, this application will be made available in alternative format.