

Reference Number _____

Date of Request _____

REQUEST FOR MEDIATION

Parent(s) Name: _____

Address City/State/Zip: _____

Phone Number(s): _____

USD/Coop/Interlocal
No. & Name: _____

Address/City/State/Zip: _____

Contact Name: _____

Phone Number(s): _____

Student for whom mediation is requested:

Name: _____ Disability _____

Birthdate: _____

Has a due process hearing been requested? yes no

Has a hearing been scheduled? yes no If yes, please state the date: _____

Please indicate preferred dates and times you are available for a mediation session.
Unless there is an emergency situation requiring immediate resolution, please allow
approximately two weeks time for the selection of a mediator and for the mediator to setup
a mediation session.

Preferred Dates: _____

Please FAX & mail to: Mediation Consultant
Special Education Services
KS State Dept. of Education
120 SE Tenth Avenue
Topeka, KS 66612-1182
Phone: (800) 203-9462 or (785) 296-5478
FAX: (785) 296-6715