CONTRACT A - Z

Carlson Home / Hospital School

HOME TEACHER WEEKLY SCHEDULE

PLEASE FAX BY 8:00 A.M. EVERY MONDAY MORNING TO (818) 505-0246.

Teacher Name _____ Home Phone _____ Voice Mail Ext. _____

School Mail Site _____ Mail Region (if elementary) _____ Pager/Cell _____

Date: From _____ 20 ____ To _____ 20 ____ Carlson Rep. _____ Voice Mail Ext. _____

Student Name	IEP	Map Page & Coord.	Student Phone No.	Medical Exp.	MONDAY *Lunes* BEG. END	TUESDAY *Martes* BEG. END	WEDNESDAY *Miercoles* BEG. END	THURSDAY *Jueves* BEG. END	FRIDAY *Viernes* BEG. END

TEACHER'S SIGNATURE _____

INSTRUCTIONS:

1. Complete the teacher information.
2. Indicate the dates of the week reported.
3. Print the name, if the student has an IEP, map page and coordinates, telephone number and medical expiration date of scheduled students.
4. Indicate the **beginning** and **ending** instructional time in each daily slot.
5. Sign the ***Weekly Schedule***.
6. Mail or Fax the ***Weekly Schedule*** to the Carlson office. The schedule must be received by **8:00 a.m., Monday**.
7. Notify the Office Representative **immediately** of any changes in the schedule.

KC 10/08