



Observation Request Form

Date Request Submitted: _____

Name of Observer: _____ Position/Title: _____

School District/Business/Agency: _____

Name of Child being Observed: _____

Date(s) and Time of Observation Requested: _____

Duration of Observation Requested: 30 min or less 30 min to 1 hour 1-2 hours Other: _____

Describe the Purpose/Intent of Observation Requested: _____

Do you know or are you aware of anyone affiliated with the Quad Cities Autism Center, Inc., either employed or receiving services currently or having received services in the past? (please circle) **YES NO**

If yes, please explain: _____

All observation requests are subject to prior approval. You will receive notification prior to your requested date. Please mail, email or fax this form to Michelle Smyth at the Quad Cities Autism Center, Inc. Thank You.

Observer's Signature _____ Date _____

FOR OFFICE USE ONLY

Date Request Received: _____

Approved or Denied

Parent Approval: _____

(please circle)

If request was denied, what was the reason: _____

Michelle Smyth, Director

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