Office of Professional Learning and Family Engagement
8270 Willow Oaks Corporate Drive
Fairfax, VA 22031

AUTHORIZATION TO DISCLOSE FCPS PROFESSIONAL LEARNING RECORDS

Former Employee Whose Records Will Be Disclosed:

Name: _____ Date: _____

Employee ID: _____ Dates Employed: _____

Most Recent Location: _____ FCPS Network Username: _____

Email Address: _____ Current Phone: _____

Identification of the Professional Learning Records To Be Released:

☐ Professional Development/Training Transcript

☐ Other, please identify: _____

_____

_____

Person or Entity That Will Receive the Professional Learning Records:

I hereby authorize FCPS' Office of Professional Learning and Family Engagement to disclose my individually identifiable records to the following:

_____ _____

Entity or Myself, Representative, Spouse, Child or Other

Email Address: _____ Phone: _____

Certification and Acknowledgement:

I certify that I am the person (*or personal representative of the person as verified by power of attorney or signed authorization from person*) designated above. I agree that my individually identifiable FCPS records will be disclosed to the person, or entity listed above. I release Fairfax County Public Schools from any liability in connection with its release or use.

_____ _____

Print Name Date

Press Submit below to complete and return form

SUBMIT