

## Advanced Academic Programs Full-Time AAP (level IV) Services Referral Form

Student Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Student ID \_\_\_\_\_ Current School \_\_\_\_\_

Grade \_\_\_\_\_ FCPS Classroom Teacher \_\_\_\_\_

FCPS Advanced Academic Resource Teacher \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Telephone \_\_\_\_\_ Email \_\_\_\_\_

Home Address \_\_\_\_\_

*Screening for subject specific advanced differentiation (level II) and part-time AAP (level III) takes place at FCPS elementary school sites. Contact the local school Advanced Academic Resource Teacher for information.*

In the space below, please provide information to explain why the student should be considered for full-time AAP services. Include information to support the committee's understanding of your student's learning needs. Suggestions include examples of critical and creative thinking, areas of strength, languages spoken by the student, a summary of how special learning needs, such as the need for an IEP or 504 Plan, might help the committee understand your student's profile of needs.

Name and Signature of Referral Source \_\_\_\_\_

Relationship to Student \_\_\_\_\_ Date of Referral \_\_\_\_\_