

**EARLY BRAILLE WRITING PROJECT**

**STUDENT REQUEST FORM**

**Student Name:**

**Student Grade Level (in September):**

**Kindergarten** **Grade One** **Grade Two** **Grade Three**

**Has this student received a MB Brailler through EBWP in the past?  Yes  No**

**If yes, in which grade(s)? Kindergarten Grade One Grade Two Grade Three**

**PEN:**

**District No:**

**District Name:**

**School Address:**

School Name:

Street Address:

City/Town:       Postal Code:

**Shipping Address (if not the school):**

Location:

Street Address:

City/Town:       Postal Code:

**Teacher of Students with Visual Impairments**

**Name:**

**Teacher Phone #:** **Teacher Email:**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

Please note: By signing above, the Teacher of Students with Visual Impairments acknowleges that she/he has read and agrees to adhere to the conditions of the Early Braille Writing Project as outlined in the Program Information document.

**Please return forms to PRCVI via email (**[**registration@prcvi.org**](mailto:registration@prcvi.org)**) or fax (604-261-0778).**