# South Dakota Advisory Panel for Children with Disabilities

## Applicant Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name: |  |  |  | Date: |  |
|  | Last | First | M.I. |  |  |
| Address: |  |  |
|  | Street Address | Apartment/Unit # |
|  |  |  |  |
|  | City | State | ZIP Code |
| Phone: |  | Email |  |

|  |  |
| --- | --- |
| Occupation: |  |
| Place of Employment: |  |

## Background Information

1. Have you ever served on an advisory panel for the State of South Dakota?

[ ]  Yes List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  No

1. The following roles are required on the State Advisory Panel. Choose the roles that would apply to you. (check all that apply)

[ ]  Parent of a child with a disability who is under the age of 26

[ ]  Individual with a disability

[ ]  Teacher

[ ]  Educator, post-secondary

[ ]  Transition Provider

[ ]  Board Member

[ ]  Administrator

[ ]  Advocate

[ ]  Representative of Private School

[ ]  Representative from the State juvenile and adult corrections agencies

[ ]  State Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Check the following that best describes you *(optional)*

[ ]  Asian

[ ]  Black/African American

[ ]  Hispanic/Latino

[ ]  American Indian/Alaskan Native

[ ]  Native Hawaiian/Pacific Islander

[ ]  White (not Hispanic)

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Check the following disability category that best represents your child or students you serve. (Check all that apply)

[ ]  Deaf-Blindness

[ ]  Emotional Disturbance

[ ]  Cognitive Disability

[ ]  Hearing Loss

[ ]  Specific Learning Disability

[ ]  Multiple Disabilities

[ ]  Orthopedic Impairment

[ ]  Visual Impairments

[ ]  Deafness

[ ]  Speech/Language Impairment

[ ]  Other Health Impaired

[ ]  Autism Spectrum Disorder

[ ]  Traumatic Brain Injury

[ ]  Developmental Delay

1. Why are you interested in serving on the panel?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Applicants with disabilities, please list any specific accommodations you will need to attend meetings. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. If you know of other qualified individuals who would be interested in serving on this panel, we would be happy to send them an application form. Please provide contact information below. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## References

Please list three references, with contact information.

1. Name: Phone:

Relationship:

1. Name: Phone:

Relationship:

1. Name: Phone:

Relationship:

**Please return completed application to:**

SD Department of Education, Special Education Programs

ATTN: Wendy Trujillo

800 Governors Drive

Pierre, SD 57501

Wendy.Trujillo@state.sd.us