

APPEAL OF A DENIAL OF AN INTERDISTRICT TRANSFER REQUEST

(Please print or type all material except signature)

TO: Santa Cruz County Office of Education

400 Encinal St. Santa Cruz, CA 95060 (831) 466-5900

ATTN: Verenise Valentin

Clerk to the Board of Education

Superintendent's Office vvalentin@santacruzcoe.org

In accordance with Education Code § 46601, and the Santa Cruz County Board of Education Policy, I/we hereby request a hearing for the purpose of Appealing an Interdistrict Transfer Denial.

Data		
Date		
Appellant Parent(s) or Guardian(s)		
Residence		
Telephone	Business Telephone	
Email Address		
Student	Age	Grade
Student	Age	Grade
School district of residence		
School district the student(s) wishes to attend _		
School district which denied your request		
Does the student(s) attend the school in the dist	trict of residence now?	Yes No
Explain if answer is "No":		

(over)

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Explain why you have requested an interdistrict transfer. Include any facts that you believe will help your appeal. If you need more space, please attach a sheet to this form.			
	-		
The appeal hearing will be held in open session. Should the parer Board consider sensitive personal information such as medical request to that effect.			
I hereby request a closed session to consider sensitive pe	rsonal information.		
Signature of Parent/Guardian Filing Appeal	 Date		
I understand that the Santa Cruz County Board of Educati decide my appeal. I hereby certify that is information is knowledge.			
Signature of Parent/Guardian Filing Appeal	Date		
Please attach any documentation denying your interdistri	ct transfer request:		
(1) Your transfer request form;			
(2) Any governing board notification from your district of residence	ce regarding your request;		
(3) Any governing board notification from the denying district reg	arding your request;		
(4) Any additional documentation that is pertinent to your reques	t.		
This information will be received by all County Board members to	help them arrive at a decision regarding		

your appeal.