

"REQUEST FOR ACCELERATION" FORM

Child referred for acceleration _____ ID# _____

Child's current school and grade level _____

Parent/Guardian Name _____

Child's Address and Phone Number _____

Referred by (Name and Title) _____

Please explain why you feel this child should be accelerated: _____

Please check the type of acceleration you are seeking for this child:

_____ Whole-grade Acceleration _____ What grade level(s)?
_____ Subject Acceleration _____ What subject(s)?
_____ Early Entrance to Kindergarten
_____ Early High School Graduation
_____ Other _____ Please specify.

Signature of Referring Party _____ **Date** _____

*A team meeting will be set up within 30 days of the receipt of this form.
If psychological testing is needed, the Acceleration Team will meet within 30 days after testing is completed.
The Office of Psychological Services must complete testing within 60 days of the testing referral
from the Office of Gifted Education.

PLEASE RETURN THIS FORM TO:
The Office of Gifted Education
1440 Lakeside Avenue, Room 217
Cleveland, Ohio 44114

“The primary goal of the Cleveland Metropolitan School District is to become a premier school district in the United States of America.”