



Office of the



State Superintendent of Education

**Transitory Services
Education of Homeless Children and Youth Program
Office: (202) 741-6412
Fax: (202) 741-0227**

SCHOOL OF ORIGIN/TRANSFER AFFIRMATION FORM

Person Completing Form: _____ Title: _____ Date: _____

School of Origin (the last school in which the student was enrolled):

Student's Name: _____ Age: _____

Grade: _____ Address: _____

Contact Number: _____ Name of Parent/ Guardian: _____

Current Address: _____

PLEASE SELECT ONE:

I would like to continue to attend my school of origin	<input type="checkbox"/>
I would like to transfer to the boundary school of my current DC residence	<input type="checkbox"/>

Name and location of the selected school: _____

Student's Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

Case Manager: _____

(Please print)

Contact Number: _____

Part 2 Completed by the DC OSSE Office of Transitory Services Education Homeless Children and Youth Program

Date Received: _____

APPROVED	<input type="checkbox"/>
DENIED	<input type="checkbox"/>

Coordinator's Signature: _____

Date: _____

Date forwarded to the designated Principal: _____