/ THE UNIVERSITY OF THE STATE OF NEW YORK / ALBANY, NY 12234

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APPLICATION FOR TUITION ASSISTANCE PROGRAM FOR DEAF INFANTS

Infant's Name: ______________________ ______________________ Sex: ☐ F ☐ M
(Last) (First)

Date of Birth: ____________ ____________ ____________ Age in Months: ____________
(Month) (Day) (Year)

How long has this infant been a resident of New York State? ______________________

STATEMENT OF PARENT OR LEGAL GUARDIAN

I, the parent or legal guardian of the above-named infant, hereby apply for admission for my deaf infant to the deaf infant program at (fill in name of approved agency) ______________________
and for State assistance for the approved educational program. I hereby grant permission for the release to the State Education Department of necessary docume

Signature: ______________________ Date ______________________

Address: ______________________ ______________________ __________ __________
(Street) (City) (State) (Zip Code)

County: ______________________ Telephone Number: ______________________

☐ Yes ☐ No