(Non-Brailler) PREMIUM EQUIPMENT REPAIR ORDER

NAME OF VISION COORDINATOR OR STATE APPROVED SPECIAL EDUCATION DIRECTOR: _____ **DATE** **SIGNATURE**	**ILLINOIS INSTRUCTIONAL MATERIALS CENTER** **1850 W. ROOSEVELT RD** **CHICAGO, IL 60608-1228** **PHONE: 312.997.3699 FAX: 312997.1687** **IIMC@CHICAGOLIGHTHOUSE.ORG** **NEED BY: _____**	**OFFICE USE ONLY** **REPAIR ORDER #:** RECEIVED: PROCESS START:

TVI CONTACT INFORMATION		**SHIPPING ADDRESS** *Where is the equipment located?* Repaired items will be sent back to this address.
NAME:	EMAIL:	SCHOOL/DISTRICT:
WORK TITLE:	PHONE:	ATTENTION:
DISTRICT/AGENCY:		ADDRESS:

REQUIRED STUDENT INFORMATION *Who is the equipment assigned to?*					
NAME					
DOB					
GRADE					

QTY:	**Item Description & Model** Information	Manufacturer	**ASSIGNED TO:** *(student name/init)*	**PROBLEM DESCRIPTION**	**SERIAL NUMBER**

DO NOT USE THIS FORM FOR BROKEN PERKINS BRAILLERS.
DO NOT USE THIS FORM TO ORDER NEW REPLACEMENT EQUIPMENT.