

**Maria Moleski, Ph.D.**

CA Licensed Psychologist PSY19434  
Child & Adolescent Neuropsychologist  
Licensed Educational Psychologist  
Certified School Psychologist



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**Request for School Observation**

I, \_\_\_\_\_, parent or legal guardian of  
\_\_\_\_\_, indicate by my signature on this form that I have  
requested, a classroom observation of my child by Dr. Maria Moleski.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name of School: \_\_\_\_\_

Address of School: \_\_\_\_\_

City: \_\_\_\_\_

Contact Person at School (usually Principal or Vice Principal):

\_\_\_\_\_

Phone # of Contact Person: \_\_\_\_\_

Classroom(s) for Observation (Teacher(s) names, Classroom #(s), Subject(s)  
Taught:

\_\_\_\_\_

\_\_\_\_\_