

OSERS PEER REVIEWER DATA FORM

Thank you for your interest in being a peer reviewer for the Office of Special Education and Rehabilitative Services (OSERS). By responding to the following questions, you can assist us in making appropriate selections for peer review panels. The statement asks for demographic information about yourself. If possible, we ask that you transmit the form electronically to OSERS Peer Reviewer email address at: OSERSPRS@ed.gov. Please type or print your answers. We appreciate your time in completing this form.

1. Dr./Mr./Mrs./Ms. _____
First Name
Middle Initial
Last Name
Ms.

2. **Gender:** Male Female

3. **Home Address:**

P.O. Box _____
 Street _____
 City, State & Zip Code _____
 Phone Number _____ TDD Number _____
 Fax Number _____ E-mail Address _____

4. **Work/Alternate Address:**

Employer _____
 Department _____
 Position _____ Title _____
 P.O. Box _____
 Street _____
 City, State & Zip Code _____
 Phone Number _____ TDD Number _____
 Fax Number _____ E-mail Address _____

Please check **one** address (home or work/alternate) for each type of correspondence.

Financial Address	Address where financial documents (e.g., 1099's, honorarium and per diem checks) will be sent.	<input type="checkbox"/> Home <input type="checkbox"/> Work/Alternate
FedEx Address	Address where confirmation packets, applications, and airline tickets will be sent. Must include a street (i.e., cannot be a P.O. Box).	<input type="checkbox"/> Home <input type="checkbox"/> Work/Alternate
Roster Address	Address that will appear on the panel roster for dissemination to other peer reviewers.	<input type="checkbox"/> Home <input type="checkbox"/> Work/Alternate

5. **Ethnicity:** Are you (select only one)

- Hispanic or Latino
- Not Hispanic or Latino

Race: Are you (select one or more)

- American Indian or Alaska Native
- Native Hawaiian or other Pacific Islander
- Asian

Native Hawaiian or other Pacific Islander

- Black or African American
- White

6. **Disability:**

Please check box(es) if you are:

- Individual with a Disability
- Spouse/Partner of an Individual with a Disability
- Parent of an Individual with a Disability-
 - a. Please provide the birth date of your youngest Child with a Disability
- Sibling of an Individual with a Disability

(Any reasonable accommodations required by reviewers will be provided.)

Paperwork Burden Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number. The valid OMB control number for this information collection is **1820-0583**. The time required to complete this information is estimated to average **.30** hours (or minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. **If you have any comments concerning the accuracy of the time estimate (s) or suggestions for improving this form, please write to:** U.S. Department of Education, Washington, D.C. 20202-4651. **If you have comments or concerns regarding the status of your individual submission of this form, write directly to:** U.S. Department of Education, Office of Special Education and Rehabilitative Service, Grants and Contracts Services Team, Attn: Lewis Medley , 400 Maryland Avenue, S.W. Washington, D.C. 20202-2550.