

FRANKLIN B. WALTER OUTSTANDING EDUCATOR AWARD

Educator Release Form - Return via email by 4/17/25

(Please print clearly)

Name _____

Address _____

(Street/PO Box)

City) (State) (Zip)

Phone (____) _____

Email _____

The following educator/team _____ authorize the

_____ School District (School District Name), the

State Support Team Region 1,

and the Ohio Coalition for the Education of Children with Disabilities and/or

their authorized agents to release publicly my name, use videotapes,

photographs, and otherwise publish or cause to be published any information

relevant to my achievements supporting my selection for recognition of

outstanding achievement. This information may be used in local, regional,

state, or national publications of the agencies listed above as well as be

released to appropriate newspapers and/or news publications.

I authorize release of the above information for the purposes stated.

Signature(s) _____ Date _____

Signature(s) _____ Date _____

Signature(s) _____ Date _____

Signature(s) _____ Date _____

Signature(s) _____ Date _____

Signature(s) _____ Date _____

Email completed form to Tamie Cruz at esclew_tc@sstr1.org by April 17, 2025