NASSAU COUNTY DEPARTMENT OF HEALTH - PRESCHOOL SPECIAL EDUCATION PROGRAM

SUMMER 2013 - MONTHLY SERVICE REPORT - RELATED SERVICES/SEIT

ATTENDANCE RECORD MUST BE KEPT CUMULATIVE

IF A STUDENT HAS MORE THAN ONE TEACHER FOR A SERVICE - THE ATTENDANCE MUST BE COMBINED

NAME OF STUDENT: ______________________ **DOB:** ______________ **DISTRICT:** ______________________

AGENCY/PROVIDER: ______________________ **SERVICE TYPE:** ______________ **START DATE:** ______________________

(ST, OT, PT, CO, SEIT etc.)

THERAPIST: ______________________ **TITLE/LIC#:** ______________________

(check box if it applies)

☐ TSHH ☐ TSSLD ☐ COTA ☐ PTA ☐ LPN

APPROVED # OF SESSIONS PER WEEK : ______________________

(2X30,2X45,2X60,etc) (Frequency and Duration as per IEP)

AMENDED # OF SESSIONS P/W: ______________________

AS OF THIS DATE: ______________________

YOU MUST ENTER THE # OF MINUTES FOR SERVICES PROVIDED

S/30 (CPSE Meeting for Related Service only); CO/30 (Coordination for Related Service only); CA (Child Absent); TA(Teacher Absent); H (Holiday) MU (Make Up-Include # of Minutes)

	WEEK - 1							WEEK - 2							WEEK - 3							WEEK - 4							WEEK - 5								
	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M	T	W	TH	F	S	S	M
JU					Ind Day																																
L		1	2	3	4*	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31					
AU																																					
G					1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31		

* SED Legal Holidays-No services are to be given

I hereby certify that the list of services provided on this form is a true and accurate representation of the facts and that all services were in compliance with the laws and agreements governing the Preschool Supportive Health Services Program. If any of the above services were provided by a COTA, PTA, TSHH, TSSLD, or LPN, then I further attest that proper supervision has been provided as per each discipline's Practice Acts and all applicable laws. In addition, I certify that treatment logs for each session have been accurately and contemporaneously completed. I am aware that deliberate filing of false information may result in criminal penalties.

SUPERVISOR SIGNATURE: ______________________ **TITLE:** ______________________

** Supervisor signature required if above signed by a TSHH, TSSLD, COTA, PTA, or LPN

AUTHORIZED SIGNATURE: ______________________ **TITLE:** ______________________

Original signatures required