RELATED SERVICE DAILY SESSION NOTE FORM

Child's Name:________________________________ **DOB:**________________ **IEP PERIOD:** ___/___/___ to ___/___/___

(Full Name as it appears on the IEP) **Print Name of Agency:**_______________________________________

Service Type: ______________________________ **Print Name of Provider:** ____________________________________

Attendance Code (Att. Code):
Scheduled Session: **SS,** Therapist Canceled: **TC**,
Family Canceled: **FC,** Holiday: **H,**
Inclement Weather: **IC,** Makeup Session: **M**

LOCATION OF SERVICE AS PER CHILD'S IEP
PLEASE PRINT THE FULL ADDRESS(ES) SERVICES TOOK PLACE:

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License #	DATE

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License #	DATE

Date: / / **Start Time:** **End Time:** **# in Group** _________ **Individual** _________
Att. Code: **Makeup Date:** / / **Location:** **CPT Code:**

Briefly describe progress made towards IEP goals and any comments:

Provider Signature / Title / License # / NPI #	Supervisor Signature / Title / License #	DATE

I have read the above service logs and agree that the services were delivered as written.

____ Date: ______________________

Signature of ( ) Parent ( ) Guardian/Surrogate ( ) Child Care Provider * ( ) Other

* Provider is required to obtain written authorization from parent/guardian for childcare provider to review and sign record of service

If provider is a TSHH/TSSLD, COTA or PTA, LPN, LMSW, the therapist providing "under the direction of" or supervision MUST sign the following. I have provided the "under the direction of"/SED required supervision for the therapist signing above.

Signature of Supervising Therapist Licensed & Registered	**Print Name**	**License#/Certification/Title**	**NPI#**