SERVICE DAILY SESSION NOTE FORM

Itinerant Related Service Only (e.g. Home/Community)

Child Name: ______________________ **DOB:** ________ **IEP Period:** ________ **to** ________
Service Type: ______________________ **School District:** ______________________
Name of Agency: ______________________ **Print Name of Service Provider:** ______________________

Attendance Code (Att. Code):	**Location of Service as per IEP: (Use Code)**
Schedule Session: **SS** Family Canceled: **FC** Therapist Canceled: **TC** Holiday: **H**	School: **S** Facility: **F** Home: **H**
Inclement Weather: **IC** Makeup Session: **M** Discharged: **D**	Other: **O**, specify ________

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 / Designation / License # / NPI #	
Supervisor Signature / Designation / License #	

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 / Designation / License # / NPI #	
Supervisor Signature / Designation / License #	

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 / Designation / License # / NPI #	
Supervisor Signature / Designation / License #	

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 / Designation / License # / NPI #	
Supervisor Signature / Designation / License #	

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 / Designation / License # / NPI #	
Supervisor Signature / Designation / License #	

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 direction of"/SED required supervision for the therapist signing above.

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