



RELATED SERVICE DAILY SESSION NOTE FORM

Child's Name: (Full Name as it appears on the IEP)
DOB:
IEP PERIOD:
Service Type:
Print Name of Agency:
Print Name of Provider:

Attendance Code (Att. Code):
Scheduled Session: SS Family Canceled: FC Therapist Canceled: TC Holiday: H
Inclement Weather: IC Makeup Session: M Face to Face: FF
Location of Service as per IEP:
USE LOCATION ON IEP:

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

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 CPT Code:
Att. Code: Makeup Date: / / Location:

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 CPT Code:
Att. Code: Makeup Date: / / Location:

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.

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

* 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#