

NASSAU COUNTY DEPARTMENT OF HEALTH - PRESCHOOL SPECIAL EDUCATION PROGRAM
WINTER 2009-2010 - NON CENTER-BASED 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

AGENCY/PROVIDER: _____ SERVICE TYPE: _____ DISTRICT: _____
(ST, OT, PT, CO, SEIT etc.)

THERAPIST: _____ LIC #: _____ SUPERVISOR: _____

NAME OF STUDENT: _____ DOB: _____ SUPERVISOR TITLE/LIC #: _____

APPROVED # OF AMENDED # OF

SESSION PER WEEK (2X30,2X45,2X60,etc) : _____ SESSIONS P/W: _____ AS OF:(DATE) _____

YOU MUST ENTER THE # OF MINUTES FOR SERVICES PROVIDED

(For Service Type Provided -Indicate # of minutes); S/30 (CPSE Meeting for Related Service only); CO/30 (Coordination for Related Service only);
 E(Evaluation);ET(Eval Testing); CA (Child Absent); MU/(#OF MINUTES) (Make Up); TA (Teacher Absent); H (Holiday)

	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
SEP									Lab Day																										
OCT																Col Day																			
NOV																																			
DEC																																			
JAN																							MLK Day												
FEB																																			
MAR																																			
APR																																			
MAY																																			
JUN																																			

* 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. I am aware that deliberate filing of false information may result in criminal penalties.

THERAPIST SIGNATURE: _____ Title: _____

If OT/PT is provided by a COTA/PTA, the supervising NYS Licensed OT/PT must co-sign this form. If ST is provided by a TSHH/TSSLD/CFY, the supervising NYS Licensed SLP must co-sign this form.

Supervisor Signature: _____ AUTHORIZED SIGNATURE: _____ TITLE: _____