

**SUFFOLK COUNTY  
PRESCHOOL SPECIAL EDUCATION PROGRAM  
RECORD OF RELATED SERVICES LOG NOTES**

**Voucher #** \_\_\_\_\_

**Voucher Date** \_\_\_\_\_

1. Student's Name (Last, First)		2. Month/Year of Service	
3. Name of Service Provider Agency (if applicable)		4. Name of Individual Service Provider	
5. IEP Start Date to End Date	6. IEP Service Frequency and Duration	7. Location of Service Delivery	8. License # of Provider and Expiration Date
9. Type of Related Service (check one) <input type="checkbox"/> Speech/Lang. <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Psych. Services <input type="checkbox"/> Social Work <input type="checkbox"/> Vision Educ. <input type="checkbox"/> Parent Training <input type="checkbox"/> Teacher Assistant <input type="checkbox"/> Other_____			

Date of Service: \_\_\_\_\_ Make-up Session: Yes [ ] No [ ] Time of Session: \_\_\_\_\_ to \_\_\_\_\_

IEP Goal(s) targeted: \_\_\_\_\_

Activity/Lesson: (Including objectives and measures of success) \_\_\_\_\_

Response (s) of Child: \_\_\_\_\_

Print name of Parent/Caretaker: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caretaker and date \_\_\_\_\_

**DO NOT SIGN BLANK LOGNOTES**

Date of Service: \_\_\_\_\_ Make-up Session: Yes [ ] No [ ] Time of Session: \_\_\_\_\_ to \_\_\_\_\_

IEP Goal(s) targeted: \_\_\_\_\_

Activity/Lesson: (Including objectives and measures of success) \_\_\_\_\_

Response (s) of Child: \_\_\_\_\_

Print name of Parent/Caretaker: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

To the best of my knowledge, the session specified above has occurred.

Signature of Parent/Caretaker and date \_\_\_\_\_

**DO NOT SIGN BLANK LOGNOTES**

14. Session	Number	Total Units		Rate	Total per page
<u>Duration</u>	<u>of Units</u>				
30 min	= 1 unit				<b>Total for all pages</b>
60 min	= 2 unit		X		

15. To the best of my knowledge, sessions occurred as specified above.

**Parent/Guardian Print and Sign name and date:** \_\_\_\_\_ / / \_\_\_\_\_

16. I certify that the above services were provided on the dates and times indicated in accordance with the Student's IEP and the Related Service Agreement. \_\_\_\_\_

**Signature of Related Service Provider**

**License or Certification #**

**Date**