RELATED SERVICES PROGRAM
RECORD OF SERVICES

Student's Name (Last, First):_____ Student's NYC ID#: _____

Provider's Name: _____Service Mandate: _____

Type of Service Provided: _____Group or Individual Mandate: _____

RELATED SERVICE SESSION NOTES

Date of Session	Start/End Time	Location of Service	Notes on Session
____/____/____	____to_____		
____/____/____	____to_____		
____/____/____	____to_____		
____/____/____	____to_____		
____/____/____	____to_____		
____/____/____	____to_____		
/ _/	to		

I hereby certify that the above services were provided on the dates and times indicated herein, and in accordance with the child's IEP, and that, to the best of my knowledge, the information on this form is free from any material misrepresentations. I understand that when completed and filed, this form becomes a record of New York Therapy Placement Services, Inc.

_____ DATE: _____
(Signature of Provider)

_____ DATE: _____
(Signature of Supervising Clinician - required for Speech Clinical Fellows ONLY)