Service Documentation Form

School District/Provider Number: ______________________

Student Name: ____ Date of Birth: ____________________

Medicaid ID Number: ________________________________ Type of Therapy: _________________

Service Period (Month/year): _________________________

ACTIVITY/PROCEDURE NOTES

DATE					Individual (I) Group (G)	Service Time In minutes
					I G	
					I G	
					I G	
					I G	
					I G	
					I G	
					I G	
					I G	

Signature:__________________ Signature: __________________ Professional Signature: _________________
(Required for under the direction of)

Title: ______________________ Title: ______________________ Title: ________________________________

Date: ______________________ Date: _____________________ Date: ________________________________