NASSAU COUNTY EARLY INTERVENTION PROGRAM

PERSONNEL IN NEED OF SUPERVISION

Date: _____/_____/_____

To: Early Intervention Program, EIOD: _____

From: Provider/Agency: _____

Re: [ ]CFY-Clinical Fellowship Year [ ]COTA-Occupational Therapist Ass't [ ]PTA-Physical Therapist Ass't

Student: [ ]ST [ ]PT [ ]OT [ ]Sp Ed Teacher [ ]Other

M*ust have continuous on-site supervision for PTA and student)*

Name of Child:_____ DOB____/_____/_____

Name of: (CFY, COTA, PTA &/or Student)_____

Responsibilities:_____

_____

Name of Supervisor:_____ License Number:_____

Frequency of Observation:_____

Supervision:_____

_____

Parent/Guardian Signature:_____ Date: _____/_____/_____

Supervisor Signature:_____ Date:_____/_____/_____

[ ]Approved [ ]Not Approved Reason:_____

_____

_____

EIOD Signature:_____ Date: _____/_____/_____