Parent/Caregiver –
DO NOT SIGN BLANK LOG NOTES

NASSAU COUNTY DEPARTMENT OF HEALTH
OFFICE OF CHILDREN WITH SPECIAL NEEDS
Preschool Special Education Program

Print legibly/use black ink only

TREATMENT LOG - RELATED SERVICES

Child's Name (Last, First) DOB:	Agency / Center-Based School or Independent Contractor UP WEE GROW, INC	NPI # 1699821868	School District
Location of Service as per IEP: (Use code) O=Office, H=Home, PS=Preschool, D=Daycare, CB = Center, X=Other specify ________	Print Name of Individual Service Provider / License Number		
Type of Service: / Dates of Service (IEP Dates) to	Print Name of Individual Supervising Provider / Professional Credentials / License / NPI #		
RX or Recommendation Date / ICD9/ICD10 Codes / ☐ Individual ☐ Group Size Per IEP______	Frequency & Duration as indicated on the IEP - *Individual* Sessions Per week: Minutes:	Frequency & Duration as indicated on the IEP – *Group* Sessions Per week: Minutes:	
Town of Service / NCDOH NPI # 1558403824 / ☐integrated setting	Frequency & Duration as indicated for this provider -*Individual* Sessions Per Week: Minutes:	Frequency & Duration as indicated for this provider--*Group* Sessions Per Week: Minutes:	
** Only NON CB services require a verifying witness signature*	NPI # (Actual Therapist):		
NOTE: All sessions must be signed off by Parent or Authorized Verifying Witness, Provider and UDO/USO Supervisor for TSHH, TSSLD, CFY, COTA, PTA, LPN or Supervisor of LMSW	SESSION CODES: P-Service MU – Make Up Session CA – Child Absent TA - Therapist Absent S - CPSE Meeting T - Testing		

Date of Session	Start Time AM PM	End Time AM PM	Session Code # in Group _______	Session Notes: Activity related to IEP Goals (Including objectives and measures of success) and response(s) of child	CPT Code(s):
Child's name:					Location Code:
* Signature of Parent or Verifying Witness Date					Service Type
Provider Signature Professional Credentials Date					☐ Individual ☐ Group Size Per IEP _____
USO/UDO Supervisor Signature Professional Credentials Date				PROGRESS (CHECK ONE): ☐ Progress ☐ Limited Progress ☐ No Progress	

Date of Session	Start Time AM PM	End Time AM PM	Session Code # in Group _____	Session Notes: Activity related to IEP Goals (Including objectives and measures of success) and response(s) of child	CPT Code(s):
Child's name:					Location Code:
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Child's Name (Last, First): ________________________________ DOB: ______________________

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PROGRESS (CHECK ONE): ☐ Progress ☐ Limited Progress ☐ No Progress

CPT Code(s):

Location Code:

Service Type

☐ Individual

☐ Group Size Per IEP _____

Contact and Comments Codes: TC – Telephone Conf CN – Communication Notebook CO – Coordination R – Wkly Recommendations/Interventions for Classroom Teacher/Caregiver O – Other

Date	Codes	Notes

I certify all information entered on this Treatment Log is correct (Provider Sig.) ________________________________ Date_______/_______/_______

Treatment Log Reviewed by ________________________________ Date_______/_______/_______

Print Reviewer's Name: ________________________________