

**NOTIFICATION OF EXTENDED NONDELIVERY OF SERVICES
PRESCHOOL RELATED SERVICES**

TO: _____

Name of CPSE Chairperson

School District

Address of School District

FROM: _____

Related Service Provider and License #

Agency Name (if applicable)

Address of Related Service Provider

Phone Number

Fax Number (if any)

DATE: _____

**SUBJECT: NOTIFICATION OF EXTENDED NONDELIVERY OF RELATED SERVICES
(FIVE MISSED SESSIONS) REGARDING:**

Student's Name: _____

Date of Birth: _____

Type of Related Service: _____

Dates of Missed Sessions: Reason(s) for Missed Sessions:

1. ___/___/___ _____

2. ___/___/___ _____

3. ___/___/___ _____

4. ___/___/___ _____

5. ___/___/___ _____

**c: Suffolk County Department of Health Services
DSCSN, Coordinator of Preschool Services
50 Laser Court
Hauppauge, NY 11788**