EASTCONN
Where Learning Comes to Life

Occupational Therapy, Physical Therapy, Speech Therapy Services

Staff Name: _____ Program Site/LEA: _____ Month/Year: _____ Date Submitted _____

Name (last, first)	Time on IEP																								Total time per student
Total per day:																									

Codes: C = Staff Consult/Parent & Student Meeting (PPT/IEP); **D** = Direct Service; **E** = Evaluation; **M** = Meeting (such as PD/Seminar); **NS** = Holiday/Snow/Delay; **R** = IEP/Report Writing; **SA** = Student Absent; **SCR** = Screening; **SRA** = School Related Activity (field trip, testing, etc.); **SS** = Staff Supervision or Training; **TA** = Therapist Absent; **TNA** = Therapist Not Available (other meeting, etc.)
Please write the time seen (in minutes or decimal) and the code Ex: 15 D or .5 C etc.) in each block each time a student is seen or when activities are performed on the student's behalf.

Monday Afternoon Activities: _____ _____ _____ _____ _____