Provider of Supervision – Speech, PT, OT

Name of Student: _____ IEP Term: _____ to _____

MaineCare Section: ☐ Speech and Hearing ☐ Occupational Therapy ☐ Physical Therapy

Practitioner Providing Service: _____

Supervising Practitioner: _____ Credential: _____

Date of IEP Review (Plan of Care/Service): _____

Dates of Direct Observation of Student: _____
(recommended once per quarter)

_____

_____

_____

Dates of Consultation with Supervisee: _____

(Quarterly)

_____

_____

_____

Dates of Documentation Review _____
(Quarterly)

_____

_____

_____

I certify that all the information documented above accurately reflects my role as the supervisor of the practitioner listed above.

_____ _____
Signature of Supervising Practitioner Date