

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