Documentation of Supervision of Services Provided by Certified Physical Therapist Assistant "Under the Direction Of"

Student Name:	Date of Birth:	Diagnosis:
Name of PTA: Name of Supervising PT:	School Year:	
Date of Initial face-to-face Contact:		

Review of IEP/Evaluations *(at minimum at the beginning of the school year or the beginning of treatment for new students):*	
Date:	Date:
Direct Observation:	
Date:	Date:
Date:	Date:
Review of Medicaid Documentation:	
Date:	Date:
Date:	Date:
Conference with supervising physical therapist:	

Date:	Notes:

Other Relevant Data:	
Date:	Notes:

Supervisor's Signature:_____Date:_____