NOVEMBER 2021 NOTES

THERAPIST NAME: _____ **DISCIPLINE:** _____

COMPANY NAME : A. AMERIMED EARLY INTERVENTION PROGRAM **THERAPIST'S SIGNATURE:** _____

CHILD's NAME: _____

EI #: _____

Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Mandate: _____

Number of Sessions Provided: _____

Service Type: _____

CHILD's NAME: _____

EI #: _____

Su	M	Tu	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

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Number of Sessions Provided: _____

Service Type: _____

CHILD's NAME: _____

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Mandate: _____

Number of Sessions Provided: _____

Service Type: _____

CHILD's NAME: _____

EI #: _____

Su	M	Tu	W	Th	F	Sa
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7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Mandate: _____

Number of Sessions Provided: _____

Service Type: _____

LEGEND KEY

O Regular Session

X Missed Session

M Make-up Session

Please use the legend key to indicate the type of session in each calendar box

THE PROVIDER WHOSE SIGNATURE APPEARS ON THIS FORM CERTIFIES THAT THE DATE (S), TYPE, MANDATE AND SESSIONS ENTERED CORRESPOND TO THE SERVICE(S) RENDERED TO THE CHILD PURSUANT TO THE IFSP, AS APPROPRIATE, AND THAT EARLY INTERVENTION SERVICES ARE PROVIDED IN ACCORDANCE WITH PROFESSIONAL CLINICAL GUIDELINES SET FORTH BY NYS DEPARTMENT OF EDUCATION , THE NYS DEPARTMENT OF HEALTH AND MENTAL HYGIENE AND AMERIMED EARLY INTERVENTION PROGRAM

By signing this invoice, I confirm that I have received the in-service materials, including the documentation requirements for interventionists, which were mailed to me. I also confirm that I have read the in-service materials and the memorandum containing documentation requirements, understood them, have asked questions where I was uncertain, and will abide by the principles and directives contained therein. If I have not received the in-service materials and the memorandum containing the documentation requirements, I will inform Amerimed EIP in Writing that I have not received them.

Rev. Nov 2020