## NIAGARA COUNTY DEPARTMENT OF HEALTH MONTHLY TSHH/TSLD/CFY SUPERVISORY CASE NOTES

CHILD'S NAME:	DISCIPLINE:
DOB:	MONTH & YEAR:
TYPE OF SUPERVISION:	DATE COMPLETED (if applicable):
Face to Face Contact with Child/provider	
Review of Monthly Log/Case Notes	
Review of Progress/IEP Goals	
Discussion with provider re: Child's Progress	
Co-Treatment / Observation	<del></del>
General Comments regarding child's needs, goals, and procomments should be signed and dated by SLP.)	
SLP(Print Name)	(with credentials)
SLP Signature	Date:
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