

**CERTIFICATION
OF SPEECH**

UNDER THE DIRECTION AND ACCESSIBILITY

School District/Agency _____

I, _____, Licensed Speech-Language Pathologist, with current
License number _____, certify that I am providing "Under the Direction of" services to
the following Certified Teachers of the Speech and Hearing Handicapped (Therapist) for
the _____ - _____ school year:

Child's Name: _____ **Date of Birth:** _____

Name of TSHH	Certification Number
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I am providing accessibility to the Teachers of the Speech and Hearing Handicapped in the following manner: (e.g. overlapping schedules, telephone, on-site)

I will keep the appropriate records documenting that the "**Under the Direction of**" activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, **initial and subsequent periodic face to face contacts with each student** etc.)

Signature of Licensed Speech Language Pathologist

Date

SPEECH "Under the Direction of" LOG

CHILD NAME _____ DOB _____ SCHOOL YEAR _____

SPEECH SERVICES MANDATED _____

ASSIGNED TSHH _____ CERTIFICATION # _____

SUPERVISING SLP _____ LICENSE # & NPI # _____

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	SLP & TSHH SIGNATURE
IEP REVIEW				
<i>INITIAL OBSERVATION – Face to Face with Child</i>				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
<i>2nd OBSERVATION – Face to Face with Child</i>				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
<i>3rd OBSERVATION - Face to Face with Child</i>				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
<i>4th OBSERVATION - Face to Face with Child</i>				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The supervising SLP **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a TSHH "under the direction of". The SLP must have on file the manner in which he/she has provided supervision to the TSHH for each and every child being serviced.

**CERTIFICATION
OF
OCCUPATIONAL AND PHYSICAL THERAPY**

UNDER THE DIRECTION AND ACCESSIBILITY

School District/Agency _____

I, _____, licensed Occupational Therapist or

Physical Therapist with current license number _____ certify that

I am providing supervision to the following Occupational Therapy Assistant or Physical Therapy Assistant for the _____ - _____ school year:

Child's Name: _____ **Date of Birth:** _____

Name of OTA /PTA	License #

I am providing supervision and accessibility in the following manner:

- Participate in the development of the child's IEP program, signing and dating the treatment plan.
- Monitor the mandated delivery of OT services.
- Be readily available to the OTA/PTA for assistance and consultation, thru phone, email or fax.
- Perform an initial face to face contact with each student served by the OTA/PTA I am supervising and periodically observe the OTA with each student in the provision of services.
- Review periodic progress notes prepared by the OTA/PTA, consult with the OTA/PTA thru regular monthly meetings and make recommendations, as appropriate.
- Review service sheets used for Medicaid billing.

I will keep the appropriate records documenting that supervision activities have occurred (i.e. telephone logs, minutes of meetings, minutes of observations etc.)

Signature of Licensed Occupational/Physical Therapist

Date

OCCUPATIONAL / PHYSICAL THERAPY “Under the Direction of” LOG

CHILD NAME _____ DOB _____ SCHOOL YEAR _____

AGENCY _____ OT / PT SERVICES MANDATED _____

ASSIGNED OTA / PTA _____ LICENSE # _____

SUPERVISING OT / PT _____ LICENSE # & NPI # _____

I will keep the appropriate records documenting that the supervision services have occurred (i.e. telephone logs, minutes of meetings, minutes of observations, initial and subsequent periodic face to face contacts with each student and OTA / PTA)

ACTIVITY	Meeting Date	Type of Meeting (Group, Individual, Telephone Etc.)	Recommendations	OT / PT SIGNATURE OTA / PTA SIGNATURE
IEP REVIEW				
<i>INITIAL OBSERVATION - Face to Face with Child</i>				
FIRST QUARTER				
Meeting				
Meeting				
Meeting				
<i>2nd OBSERVATION - Face to Face with Child</i>				
SECOND QUARTER				
Meeting				
Meeting				
Meeting				
<i>3rd OBSERVATION - Face to Face with Child</i>				
THIRD QUARTER				
Meeting				
Meeting				
Meeting				
<i>4th OBSERVATION - Face to Face with Child</i>				
FOURTH QUARTER				
Meeting				
Meeting				
Meeting				

NOTE: The supervising OTR / PT **MUST** provide an initial (within first 2 weeks) and subsequent periodic face to face contact for each student being serviced by a OTA / PTA.

The PT must have on file the manner in which he/she has provided supervision to the PTA for each and every child being serviced. (One PT can not supervise more than four (4) PTA, per Article 136, section 3738 a.)

The OT must have on file the manner in which he/she has provided supervision to the OTA for each and every child being serviced. The supervision must be direct supervision.

