MANHASSET PUBLIC SCHOOLS
200 Memorial Place, Manhasset, NY 11030

**MONTHLY SERVICE LOG SHEET**

Name of Vendor:____________________________

Vendor Address:____________________________

City/Town____________________________ State________ Zip________ Telephone______________

Student's Name: ______________________________ Therapist's Name: ______________________________

School: ______________________ IEP Service Provided: ____________________________________

*IEP Ratio / Frequency: ___________ *(use IEP specifications – for example 1:1, 3:1, etc. as well as IEP specifications length of service – for example 30, 45, 60 min.)
*A reason/explanation is necessary for any difference from IEP frequency*

**NOTE:** All sessions must be signed off by someone *supervising/witnessing* presence of services provider.

**CODES:** P - Service, MU – Make up session, C – Parent conference, CA – Child absent, TA – Teacher Absent, TM – Team Meeting, S – CSE meeting

I certify all information listed below is correct

*****Invoices will not be processed without required signatures***

Name of Provider ________________________ ** (provider sig.) _______________________ Date: ________
(print)

Name of Supervisor_______________________ ** (supervisor. sig.) _____________________ Date: ________
(print)

| Month | | | Year | |
|---|---|---|---|---|
| Monday | Tuesday | Wednesday | Thursday | Friday |
| Date: | Date: | Date: | Date: | Date: |
| Date: | Date: | Date: | Date: | Date: |
| Date: | Date: | Date: | Date: | Date: |
| Date: | Date: | Date: | Date: | Date: |
| Date: | Date: | Date: | Date: | Date: |