**125 East Bethpage Road ~ Suite 5 ~ Plainview, New York 11803**

**Tel (516)731-5588 ~ Fax (516)577-9049**

**Scheduled Absence / Gap in Service**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Child Name: |  |  |  |  |
|  DOB:  |  |  | NYEIS# |
|  |  |  |  |
| Provider: |  |  | OSC |

**Scheduled Absence:**

This is written notification that there will be a **scheduled absence** by the therapist/parent from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_. The family and provider discussed this absence.

* Parent/Caregiver **chose to** **wait** for the provider to return (not to exceed three (3) weeks)
* Parent/Caregiver requests **a covering provider.**
* **Family vacation policy was discussed with parent**

**Gap in Service:**

There was a **Gap in the Frequency for the Authorized Service Above** on the following dates:

Due to:

|  |  |
| --- | --- |
| * Scheduling Conflicts
* Family Vacation
* Pending Updated Rx
* No Family Contact
* Other:
 | * Therapist Vacation
* Therapist Illness
* Consecutive Cancellations by Parent
* Child Illness
* Hazardous Weather
 |

*A missed session results in a gap only if no make-up is provided.*

|  |  |  |  |
| --- | --- | --- | --- |
| Completed by:  |  | Date:  |  |

***Internal Use Only:***

Copy sent to OSC :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_