Exhibit 8

Suffolk County Department of Health Services
Division of Services for Children with Special Needs
Event Log

Child's Name: _____ DOB: _____

Provider's Name: _____ Agency Name: _____

Coordinator of Services: YES [ ] NO [ ] IEP Dates: _____ to _____

The signature after each entry certifies that the information provided on this form is a true and accurate representation of the facts.

Date	Code	Notes SIGN FULL NAME AFTER EACH ENTRY	Time

Codes

CS Coordination of Services
PM Preparation for CPSE Meeting
AM Attendance at CPSE Meeting
PC Conferencing with Child's Parents
OB Observation
OC Conferencing with Other Providers
TR Travel for These Purposes
PH Phone Contact
OT Other

Time
Note the exact number of minutes for each activity listed