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

Verification of Absence and Make-up Session

Related Service Provider's Name: ______________________________ Date: ___________

Agency: __________________________________ Frequency/Duration: _____________

Child's Name: _________________________________Location of Service: ________________

Provider's Absence [ ] or Child Absence [ ]

Date (s) of Absence: ____

Reason for Absence: ____

Make-up Session Offered: [ ] Yes [ ] No Date of Make-up Session (if given): ____________

Make-up Session Declined By Parent: [ ] Yes [ ] No

Signature of Provider: ____

Signature of Parent/Caregiver: ______________________________________ Date: __________

Printed Name of Parent/Caregiver: ___________________________________

Please submit the completed form along with the original voucher to:

Suffolk County Department of Health Services
Accounts Payable Unit
225 Rabro Drive
Hauppauge, N.Y. 11788
Attn: Frank McCluskey