ACHIEVE BEYOND
Pediatric Therapy & Autism Services

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PERSONNEL IN NEED OF SUPERVISION

Date:

To: EIOD, Service Coordinator

From Provider/Agency: **Achieve Beyond**

Re: [ ]CFY-Clinical Fellowship Year [ ]COTA-Occupational Therapist Ass't

This is to notify you that an individual completing their CFY or a COTA is providing early intervention services under the supervision of appropriate qualified personnel.

Name of Child: _____ **EI#** _____ **D.O.B.** _____

Name of: (CFY, COTA): _____

Responsibilities: **Provide therapeutic services**

Name of Supervisor: _____

Discipline: SLP OTR

License Number: _____

Frequency of Observation: **as required or needed**

Supervision: **Review of Log Notes and Progress Reports, direct observation/video observation (with written parental consent), weekly trainings.**

I hereby authorize Bilinguals Inc. to release the Early Intervention records (evaluations, IFSP, session notes and progress notes) to the above supervisor for the purpose of supervision of the therapist and to ensure the quality of service to my child.

Parent/Guardian Signature: _____ Date: ____/____/____