NIAGARA COUNTY DEPARTMENT OF HEALTH
MONTHLY PTA SUPERVISORY CASE NOTES

CHILD'S NAME: _____ **DISCIPLINE: _____**

DOB: _____ **MONTH & YEAR: _____**

TYPE OF SUPERVISION:	**DATE COMPLETED (if applicable):**
_____ Face to Face Contact with Child/PTA	**_____**
_____ Review of Monthly Log/Case Notes	**_____**
_____ Review of Progress/IEP Goals	**_____**
_____ Discussion with PTA re: Child's Progress	**_____**
_____ Co-Treatment / Observation	**_____**

General Comments regarding child's needs, goals, and progress during month. (Any general comments should be signed and dated by PT.)

_____
_____
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_____
_____
_____
_____

PT(Print Name) _____ (with credentials)

PT Signature _____ Date: _____

License #: _____