Southwest Cook County Cooperative Association for Special Education

SERVICE COMPLETION REPORT

Service Provider's Name____ **Date:**________________

Student Name (if applicable):____ **Resident District #**_____

TYPE OF SERVICE PROVIDED

____ **Adaptive PE**	____ **OT/PT Eval Level 1** (less than 3 hours)	_____ **Technical Assistance**
____ **Audiological Evaluation**	____ **OT/PT Eval Level 2** (3 – 6 hours)	_____ **Visually Impaired Evaluation**
____ **Autism Consultation**	____ **OT/PT Eval Level 3** (more than 6 hours)	_____ **Visually Impaired Service**
____ **Behavior Consultation**	____ **Orientation & Mobility Evaluation**	_____ **Vocational Evaluation**
____ **Hearing Impaired Evaluation**	____ **Orientation & Mobility Service**	_____ **Other**__________________
____ **Hearing Impaired Service**	____ **Staff Development**_________________	__________________
____ **ESY OT Service**	____ **ESY PT Service**	__________________

To be completed after Evaluation ___ **Service recommended. Student add sheet to follow.**
___ **Service recommended. District therapist assigned.**
___ **Service not recommended.**

DATE OF SERVICE	SERVICE PROVIDED	HOURS
	Total Hours	

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Service Provider Signature **Date**

To be completed by Billing Clerk

Date Received:______________ **Fees:**_______________ **Invoice:**________________________________ **Bill Cycle:**____

Revised 6//16 DG/kk