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**
____ **Audiological Evaluation**
____ **Autism Consultation**
____ **Behavior Consultation**
____ **Hearing Impaired Evaluation**
____ **Hearing Impaired Service**
____ **OT/PT Level 1** (less than 3 hours)
____ **OT/PT Level 2** (3 – 6 hours)
____ **OT/PT Level 3** (more than 6 hours)
____ **Orientation & Mobility Evaluation**
____ **Orientation & Mobility Service**
____ **Staff Development**
_____ **Technical Assistance**
_____ **Visually Impaired Evaluation**
_____ **Visually Impaired Service**
_____ **Vocational Evaluation**
_____ **Other**__________________
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DATE OF SERVICE	SERVICE PROVIDED	HOURS
	Total Hours	

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Service Provider Signature **Date**

To be completed by Service Coordinator

Fees:________________________________ **Invoice:**________________________________

Revised 10/08