|  |  |
| --- | --- |
| Client Name:  | Date of Service:  |
| Time In:  | Time Out:  |
| Type of Provider:  |
| The following ***DIRECT or INDIRECT*** service(s) were conducted on the above date: (please check one) |
| **DIRECT** | **INDIRECT** |
| [ ]  Direct Observation of Client | [ ]  BASP Development/ Revisions |
| [ ]  Direct Training of Client | [ ]  Graphing and Analyzing Data |
| [ ]  Probing Behavior and Instructional Procedures | [ ]  Behavior Data Collection Development or revision |
| [ ]  Supervision/Training of Behavioral Team by Lead BCBA or BCBA-D | [ ]  Physician/Therapist/Staff/Parent Consultation or Training – Client not present |
| [ ]  Physician/Therapist/Staff/Parent Consultation or Training  | [ ]  Progress Report Development |
|  |  |
|  |  |
| [ ]  FBA – Functional Behavioral Assessment |  |

Summary of Service / Progress Towards Goals / Caregiver Proficiency / Staff Monitoring:

Clinician Signature and Credentials: Date: