Therapist Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Service Provided: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Date** | **Child Initials** | **Time In** | **Time Out** |
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Teacher Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Center: CRC \_\_\_\_\_\_\_ UTC \_\_\_\_\_\_\_ LFRC\_\_\_\_\_\_\_RFRC \_\_\_\_\_\_\_ SFRC\_\_\_\_\_\_\_ HFFRC \_\_\_\_\_\_\_ School 12 \_\_\_\_\_\_\_ School 2 \_\_\_\_\_\_\_

Therapist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Remember this sign in is for one month. At the end of the month please send sign in to:*** [***clobrien@ceoempowers.org***](mailto:clobrien@ceoempowers.org)

***Thank you!***