**OBSERVATION OF STUDENTS BY SUPERVISOR**
**For services provided by a TSHH, OTA or PTA**

☐ **Initial Observation** ☐ **Ongoing Observation**

| | | |
|---|---|---|
| **Student Name:** | | |
| **Provider:** | **Supervisor:** | |
| **Date observed:** | **Time:** | **Location:** |
| **Goals Addressed:** | | |
| | | |
| | | |
| | | |
| **For OT only - Written Supervision Plan in place and available to District for Audit purposes:** | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Please Initial and date the comments you feel are correct:**

| **COMMENT** | **Supervisor Initials and Date** |
|---|---|
| Therapy is delivered as appropriate for this pupil. | |
| Therapy is delivered in a safe and efficient manner | |
| Therapy is delivered as indicated on the student's IEP. | |
| Contact information is available to the provider | |

**SIGNATURE:**_____ **DATE:**_____

**License #** _____