Quarterly Progress Report TheraCare, Inc.

One note per quarter required. Due on the last day of each quarter.
Attach completed IEP pages.

***Check service provided*: ___ SEIT ___SCIS___Speech___OT___PT___Counseling**

***Check borough:* ___ Bronx ___ Brooklyn ___ Queens ___ Manhattan ___ Staten Island**

***Check quarter:* ___ November ___ February ___May ___ August(12 month services) Year:**

Child's Name: **DOB:**

IEP Date: **District** **OSIS#:**

Please note mastery of goals and objectives:

Report of Progress:

Provider Name: (*print your name***):**
Provider Signature: _____ Date:
Supervisor Signature: _____ Date:
