SOUTH BERGEN JOINTURE COMMISSION

Board of Education
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REQUEST FOR SERVICE FORM:

OCCUPATIONAL, PHYSICAL, SPEECH THERAPY AND/OR OTHER RELATED SERVICES

Date of this Request: _____

Case Manager: _____

Sending District: _____

Case Manager Phone: _____

Child's Name: _____

Location where services will be provided: _____

Address of service location: _____

Check Services Requesting:

- □ Occupational Therapy _____times per week x 30 minutes.
- □ Physical Therapy _____times per week x 30 minutes.
- □ Speech Therapy _____times per week x 30 minutes
- □ Other Therapy/Services _____ times per week x 30 minutes
  (Please specify therapy)_____

Requested Start Date: _____(two week lead time usually needed)

IEP: Attach copy of related services page, full therapy report, and goals and objectives

Please Note: Physical Therapy prescription from a physician is no longer required in NJ.

_____
Signature of Board Secretary or Designee C: