

THERAPIST CONFIRMATION FORM

PROGRAM YEAR: 1 2 3 SCHOOL YEAR _____ DATE: _____

STUDENT NAME: _____

Name of Therapist : _____
Credentials: _____
Address: _____

_____ Phone: _____

If you have more than 1 therapist:

Name of Therapist: _____
Credentials: _____
Address: _____

_____ Phone: _____

Name of Therapist: _____
Credentials: _____
Address: _____

_____ Phone: _____

Please complete and submit this therapist confirmation form so that it arrives in the office at least 30 days prior to the beginning of the class