			Weekly Schedule	of Related Services F	rovided for Week Ende	d			
Contract Agency: NPORT				Name of Therapist:					
Discipline:					Dist/School:				
Please complete with the time	e the child was seen	each day. The in	formation you pr	ovide MUST match w	hat you enter in SESIS	3			
		Dates:							7
Student Name	OSIS Number	Freq/Dur/Size	Monday	Tuesday	Wednesday	Thursday	Friday	Total	Comments
									_
									_
									-
								+	-
				_			+	+-	-
								+	-
								$\bot$	_
	Total Individual Ses	ssions Per Day							
# of Sessions/#of students	Total Group Sessions Per Day								
	Total Indiv/Group Sessions per day								Total (Across)
Billing Calculations # Sessions @ 30 min	y Vour	Pate ¢	-¢						
# Sessions @ 40 min	x Your Rate \$x Your Rate \$								
# Sessions @ 45 min	x Your Rate \$				Principal Printed Name Date		Date		
# Sessions @ min	x Your Rate \$		_=\$	_ (Rate x Min / 30)	Principal Signature		 Date		
			Missed Student A	Session Codes Absent SA	,				

I certify that time cards are sent per payment calendar either thru fax to (502) 413-8280 or by an encrypted email to doetherapy@nportstaffing.com using my DOE Email address.

РΑ

С

Provider Signature

Date

Provider Absent

Cancelled

Holiday

Total Due