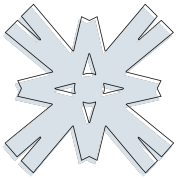
30 DAY REHABILITATIVE ASSISTANCE REVIEW LOG



SCHOOL/ DISTRICT		
LICENSED CLINICIAN		
REHABILITATIVE ASSISTANT		
STUDENT | SAU	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

- 30 DAY REVIEW DATE _____
  - Completed Y ◯ / N ◯ . If No, Reason for cancellation:
    _____

- MEETING TYPE
  - ☐ Face to Face
  - ☐ Phone Call
  - ☐ Virtual Synchronous Meeting
  - ☐ Observation

AREAS COVERED [duties and expectations, skills development]	REHABILITATIVE ASSISTANCE TRAINING [completed in last 30 days or N/A]
_____	_____
_____	_____

ISSUES IDENTIFIED WITH EFFECTIVENESS OF RA IF ANY WERE IDENTIFIED, PLEASE DESCRIBE AND IDENTIFY ACTION TAKEN TO RECTIFY
_____ _____

NEXT 30 DAY REVIEW DATE _____

LICENSED CLINICIAN SIGNATURE _____ DATE _____