UIC SPECIALIZED CARE FOR CHILDREN

TRAINING FOR EQUIPENT - THERAPIST

Child _____ Date Sent _____

DSCC # _____

Address _____

City/County _____

Parent/Guardian _____

O.T./P.T. _____

Vendor/Instructor _____

INSTRUCTIONS: Please sign and complete on the designated lines and return to our office after evaluation has been completed. Thank you for your cooperation.

I evaluated the above named child for the appropriateness of (item) _____

_____

This family/child exhibits capabilities needed to safely operate this equipment.

DATE _____ NAME AND TITLE _____

BUSINESS NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

RETURN TO: