UIC

EVALUATION/TRAINING FOR EQUIPMENT - THERAPIST (05.33-3)

DIVISION OF SPECIALIZED CARE FOR CHILDREN

Patient _____ 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 and/or training has been completed. Thank you for your cooperation.

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

_____.

This family/child exhibits capabilities needed to safely operate this equipment and/or a plan is in place to instruct.

DATE _____ NAME AND TITLE _____

BUSINESS NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

RETURN TO:

Start Over