Miami-Dade County Public Schools

Miami-Dade County Public Schools **Division of Psychological Services**

Clear Form

PSYCHOLOGICAL SERVICES MONTHLY REPORT

School Psychologist's Name: _____ **Month/Year:** _____ **Number of Days Worked:** _____

DIRECTIONS:	*Please record the number of activities completed in the designated categories below for each of your schools.* *For each school listed the principal or assistant principal must receive a copy of this monthly report.* *Return this form to the Regional Center/Program Chairperson of Psychological Services by the fifth day of the month following the month being reported.*

SCHOOLS	Support Services										Cases Tested									Open Untested Cases						Planning *	
	SST/SDT	Reevals	Progress Monitoring	FAB/BIP	Crisis	Consultations/ Counseling	IEP/EP Meetings		Professional Development		Initial		Re-eval		Gifted			Outside Reviews	Totals Cases	Initial		Re-eval		Gifted	Totals Cases	Research	Other
							Rescheduled	Participated	Attend	Present	M	B	M	B	B-Matrix	B-Auto	Plan A			M	B	M	B				
SUBTOTALS																											
TOTALS																											

M= Monolingual cases
B= Bilingual cases
*= Planning: Approved activities by immediate supervisor (per activity)

Due by the 5th of every month

FM-4279 Rev. (09-07)