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DOC TYPE 5528

**DIVISION OF SPECIAL EDUCATION**

| | |
|---|---|
| DATE (MM/DD/YY) | |
| STUDENT ID. NO. | |

PRINT STUDENT'S NAME *(LAST)* *(FIRST)* *(M.I.)*

# THERAPY QUARTERLY SUMMARY

## (Physical and Occupational Therapy Programs)

DOB: _____ IEP DATE: _____ EVALUATION DATE: _____

DATE CASE OPENED: _____ FREQUENCY: _____

DIAGNOSIS: _____

**Physical Therapy** ❑ **Occupational Therapy** ❑

THERAPIST'S SIGNATURE | THERAPIST'S NAME (PRINT) | DATE

FM-5528 Rev. (11-05)