Medical Practitioner Authorization for SBAP Services

Student's Name: _____
Participating School Name:______

Date of the current IEP Meeting: _____
MM/DD/YY

Related Services	Duration	Frequency	Projected Start Date	Projected End Date	Group	Individual
Audiology	_____	_____	_____	_____	N/A	__
Nursing	_____	_____	_____	_____	N/A	__
Occupational Therapy	_____	_____	_____	_____	__	__
Occupational Therapy	_____	_____	_____	_____	__	__
Orientation, Mobility & Vision	_____	_____	_____	_____	N/A	__
Personal Care Services	_____	_____	_____	_____	N/A	__
Physical Therapy	_____	_____	_____	_____	__	__
Physical Therapy	_____	_____	_____	_____	__	__
Psychiatric	_____	_____	_____	_____	__	__
Psychiatric	_____	_____	_____	_____	__	__
Psychological	_____	_____	_____	_____	__	__
Psychological	_____	_____	_____	_____	__	__
Social Work	_____	_____	_____	_____	__	__
Social Work	_____	_____	_____	_____	__	__
Speech & Language	_____	_____	_____	_____	__	__
Speech & Language	_____	_____	_____	_____	__	__
Hearing Impaired	_____	_____	_____	_____	__	__
Hearing Impaired	_____	_____	_____	_____	__	__
Special Transportation	_____	_____	_____	_____	N/A	__

Re-Evaluations to be provided throughout the duration of this IEP:

__ Audiology
__ Physical Therapy
__ Social Work
__ Occupational Therapy
__ Psychiatric
__ Speech & Language
__ Orientation, Mobility & Vision
__ Psychological
__ Hearing Impaired

I reviewed the Individualized Education Program (IEP) for this student and agree that the health-related services and re-evaluations recommended above by the IEP team are both appropriate and medically necessary.

Authorized Signature _____

*Date of Signature _____

Printed Name/Practitioner Title _____

License # _____

NPI# _____

MA Provider # _____

If review of medical necessity was conducted face-to-face with the student, separate documentation must be maintained.

***The date of signature is required prior to or on the date of service.**