HEALTH DEPARTMENT
Children's Services Unit

INSTRUCTIONS FOR COMPLETING
ESSEX COUNTY SEIT ATTENDANCE AND RELATED SERVICES REPORT/PARENT SIGNATURE LOG

1. **CHILD'S NAME:** Complete with the child's full name (last name, first).
2. **DOB:** Complete with the child's date of birth (month, date, year).
3. **MONTH/YEAR:** The month and year the services are delivered.
4. **ICD – 10 CODE:** Place the diagnostic code for conditions or reasons for which care is provided.
5. **AGENCY NAME:** Complete with program name.
6. **TOTAL SESSIONS DELIVERED:** Enter the **actual** number of sessions delivered for the month.
7. **MAKE UP VISITS:** Indicate the make- up service date and original service date, e.g. 09/23 is a make up for 09/17**.**
8. **SEIT / RELATED SERVICES SIGNATURE:** The individual therapist delivering the services must sign using their full name and any appropriate credentials. The form must be submitted with an original signature, photocopies are not acceptable. All providers must sign their credentials immediately after their signatures