

NAME:				
DOB:	DATE	: 	DISCIPI	LINE:
PROGRAM TIME:				
HOME EXERCISE F	ROGRAM:			
Home care service condition. Please	ces are deemed medi see current assessme	cally necess ent for detail	ary based on cl ed plan of care.	hild's medical
	has been traine	d and is competer	nt to perform the above	home exercise program.
Signature	Dat	е Тур	ped Name	Title