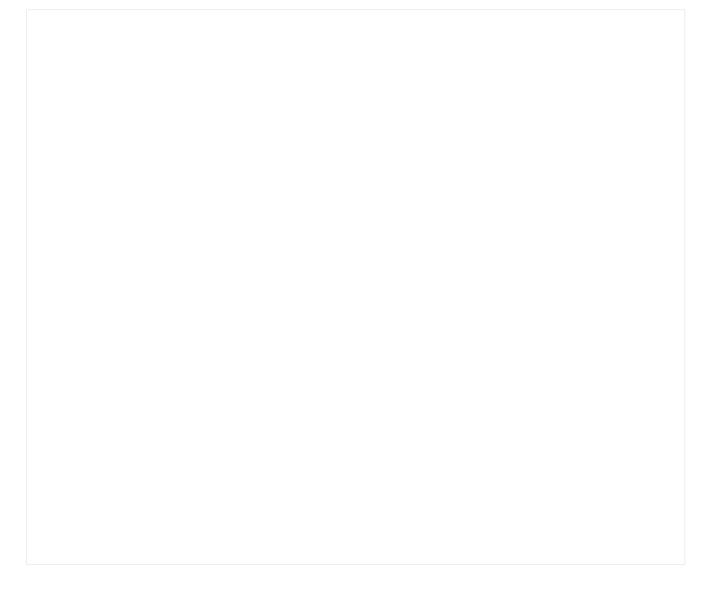


NAME:		
DOB:	DATE:	DISCIPLINE:
PROGRAM TIME:		

HOME EXERCISE PROGRAM:





HOME EXERCISE PROGRAM CONTINUED:

Home care services are deemed medically necessary based on child's medical condition. Please see current assessment for detailed plan of care.

 has been trained and is competent to perform the above home exercise program.

 Signature
 Date
 Typed Name
 Title

 Image: www.oasispediatrictherapy.com & 970-451-1234
 970-284-7892
 Image: office@oasispediatrictherapy.com