NAME: ______________________

DOB: ____________ DATE: ____________ DISCIPLINE: ____________

PROGRAM TIME:

HOME EXERCISE PROGRAM:

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

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

Signature	Date	Typed Name	Title