

**NIAGARA COUNTY DEPARTMENT OF HEALTH
MONTHLY SUPERVISORY CASE NOTES**

CHILD'S NAME: _____

DISCIPLINE: _____

DOB: _____

MONTH & YEAR: _____

TYPE OF SUPERVISION:

DATE COMPLETED (if applicable):

_____ Face to Face Contact with Child & Supervisee

_____ Review of Monthly Log/Case Notes

_____ Review of Progress/IEP Goals

_____ Discussion with Supervisee re: Child's Progress

_____ Co-Treatment / Observation

General Comments regarding child's needs, goals, and progress during month.

Supervisor Name _____ **(with credentials)**

Supervisor Signature _____ **Date:** _____

License #: _____