Note Type: ☐ **Weekly** / **Date Range**: **From** _____ **through** _____

Organization Name:	**Program Name:**	
Individual's Name (*First / MI / Last*):	**Record #:**	**DOB**:

OASAS - Attendance Note

Day	Duration	Type of Outpatient Rehabilitation Service (ORS)		Base Service (Check One)	
Monday		☐ Full Day (4+ Hours)	☐ Partial Day (2-4 hours)	☐ Individual (= or > 25 min.)	☐ Group (= or > 60 min.)
Tuesday		☐ Full Day (4+ Hours)	☐ Partial Day (2-4 hours)	☐ Individual (= or > 25 min.)	☐ Group (= or > 60 min.)
Wednesday		☐ Full Day (4+ Hours)	☐ Partial Day (2-4 hours)	☐ Individual (= or > 25 min.)	☐ Group (= or > 60 min.)
Thursday		☐ Full Day (4+ Hours)	☐ Partial Day (2-4 hours)	☐ Individual (= or > 25 min.)	☐ Group (= or > 60 min.)
Friday		☐ Full Day (4+ H)	☐ Partial Day (2-4 hours)	☐ Individual (= or > 25 min.)	☐ Group (= or > 60 min.)

Goal(s)/Objective(s) Addressed As Per Individual's Individualized Action Plan: Yes ☐ / **No** ☐

Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___	Goal ___ Objective ___ Objective ___ Objective ___ Objective ___

Summary of Services/ Interventions Provided During This Period:

Response to Services, including a chronology of the individual's participation in services/ Intervention(s), and Progress Toward Goals and Objectives:

Plan / Additional Information:

Individual's Signature (Optional):		**Date:**
Completed By - Print Staff Name/Credentials:	**Staff Signature:**	**Date:**
Supervisor - Print Name/Credentials (if applicable):	**Supervisor Signature:**	**Date:**

Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mo d 2	Mod 3	Mod 4	Start Time	Stop Time	Duration in Minutes