LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

Treatment Verification Signature Log

Therapy: ☐ PT ☐ OT ☐ SLP

Therapist: _____

Patient Name: _____

By my signature below, I certify that I was seen on the date/time indicated for skilled therapy services. I am the recipient of therapy or I am the authorized representative for this patient.

Date	Time In	Time Out	Signature
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X
			X

On _____ (date), I received: _____ from my therapist as part of my assigned home program. With these supplies, I have also been educated and received written instructions in the proper use and care of the equipment or device and understand the precautions and associated risks.

Patient Signature Witness (Therapist)