



SPEECH AND LANGUAGE PHYSICIAN'S AUTHORIZATION

SUBJECT:

DOB:

IEP/MET DATE:

GRADE:

PRIMARY DISABILITY:

ATTENDING DISTRICT:

It is my professional opinion that the above named student has been appropriately referred for Speech and language Services in accordance with the IEP listed above. This referral is valid for a 12 month period beginning with a retroactive date not greater than 90 days prior to my signature date and keeping within the active date range of the IEP listed above.

Sincerely,

Physician's Signature

Date