

CONNECTICUT STATE DEPARTMENT OF EDUCATION  
 DIVISION OF FAMILY AND STUDENT SUPPORT SERVICES  
 BUREAU OF SPECIAL EDUCATION

**SERVICE VERIFICATION FORM**  
**2013-14**

**NAME OF STUDENT:** \_\_\_\_\_  
**SCHOOL:** \_\_\_\_\_

**DISTRICT:** \_\_\_\_\_  
**DATE:** \_\_\_\_\_

Indicate which type of the special education program and related services each professional is providing to the student indicated above (Column I). Also, specify the amount of such service per week (Column II). Have professional provide signature to verify accuracy (Column III). Complete all five (5) columns.

I	II	III		IV		V
Type of Special Education Education Program or Related Services	Amount of Service Indicated on the IEP (hours or periods* per week)	Service Verified From Staff's or Student's Schedule YES      NO (check one box)		Staff Member Delivering Service		
				Signature		Title

\* if information is given in periods indicate length of periods.