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**Medical Record Maintenance Compliance Form**

I certify that I maintain the following records for each participant I treat at

*(center name)*

A prescription from a physician IF required by my practice act or local laws and regulations

A comprehensive written initial assessment including screening for precautions and contraindica- tions

A written treatment plan that includes long- and short-term goals reflective of the type of therapy

Written progress notes, completed on a regular basis, that reflect the treatment and its modifica- tions based on the response of the patient

Written periodic review, and re-evaluations completed on a regular basis that update the goals and treatment plan and make recommendations for further treatment, discharge or transition into another program

1.

2.

3.

4.

5.

Printed Health Professional Name and Credentials

Health Professional Signature/Date

**PATH Intl. Standards for Certification & Accreditation**

**2018**