125 Dillmont Drive Columbus, Ohio 43235
614-844-5433
therapy@thelearningspectrum.com

Therapy Registration Scheduling Request 2018-2019

Child's Name:
Parent/Guardian(s) Name:
Phone (Primary): **Phone (Secondary):**
Home Address:
***E-mail (Required):**

My Child is enrolled at The Learning Spectrum:

Central (Worthington) **North East (Johnstown)** **South (Canal Winchester)**
My child attends school/ programming elsewhere; needs outpatient therapy only:
I would like for my child to receive services at the following location:
Central (Worthington) **North East (Johnstown)** **South (Canal Winchester)**

I would like for my child to receive the following services utilizing the listed funding source:

Service :	**Funding Source:**
Speech Therapy	
Occupational Therapy	
Music Therapy	

***NOTE: if utilizing insurance/Medicaid, a copy of your card must be submitted with this form.**

My child receives additional therapy services outside of The Learning Spectrum:
Day: **Time:**

Please list top three day/time preferences below if your child does not attend The Learning Spectrum or needs before/after school accommodations:

My child may receive services during TLS day/school hours
Please schedule therapies back to back

Day:	**Time:**

Additional Notes:

Please return this form along with a copy of your insurance and/or Medicaid cards (front and back) to: Julia Jovanovic, M.A. CCC-SLP– Speech Language Pathologist/Therapy Director : therapy@thelearningspectrum.com