



C.H.T.Services, Inc.

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THERAPIST REPLY FORM

Please complete the following information and return to C.H,T.Services, Inc. along with your signed agreement:

Name: _____

Discipline: _____

Borough(s): _____

Bilingual Extension (CPSE) _____

Number of years of EI experience _____

Check if Applicable

Language: _____

Bilingual Evaluator: _____

Evaluator: _____

BCBA: _____

ABA Supervisor: _____

Feeding Specialist Services: _____

ABA: _____

Floor Time Training: _____

ASL: _____

Prompt Trained: _____

Behavior Specialist: _____

Sensory: _____