____________________________ SPECIAL EDUCATION UNIT

Time Certification Form

Date:

From: __________________ to ______________

This is to certify that the following individuals have worked 100% of their time during the last six months under cost objective IDEA Program, activity account number _____________ (if known).

Position	**Printed Name**	**Signature**	**Date**
Teacher	_______________________________	_________________________	_____________
Teacher	_______________________________	_________________________	_____________
Instruction Asst	_______________________________	_________________________	_____________
Teacher (ED)	_______________________________	_________________________	_____________
Therapist (SLP)	_______________________________	_________________________	_____________

I have full knowledge of 100% of these activities:

____, Unit Director _____________________ Date