



## Counselling and Therapies Timelog

### Instructions:

1. Prepare a Timelog for EACH recommended service by entering your name, student number and the type of service clearly below.
2. Use the Timelog to keep track of your sessions on an on-going basis.
3. Collect the receipts issued by your service provider as you will need to attach them to the Timelog.  
The Service Provider Declaration Form (next page) must be submitted by uploading them to your BSWD/CSG-DSE Application online or to [bswd.grants@utoronto.ca](mailto:bswd.grants@utoronto.ca) no later than the end of each term
4. You and your service provider must sign the bottom of the Timelog.

Notes: **The service provider must be a regulated health care professional in Canada.** If the service provider does not fit these criteria, your receipts cannot be accepted as accounting for this funding. Dates of service must fall within your OSAP/BSWD-eligible term (e.g. fall, winter, summer). Copy this form as needed. Keep a copy of all documents for your records.

Student's Name:

Student Number:

Type of Service:

Date of Service (day, month, year)	# of Hours	Rate per Hour	Amount Paid (Number of Hours X Rate)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
<b>Total Amount Paid for Counselling</b>			\$

\_\_\_\_\_  
Service provider's signature

\_\_\_\_\_  
Student's signature



**COUNSELLING & THERAPIES SERVICE PROVIDER DECLARATION FORM:**

Instructions:

1. Prepare a Service Provider Declaration Form for EACH recommended service by entering your name, student number and the type of service clearly below. If you have multiple service providers for a service, you need to provide a Declaration Form for each provider.
2. Ask your service provider to complete the Declaration below.

Match the Declaration with each Therapies Timelog by uploading them to your BSWD/CSG-DSE Application online or to [bswd.grants@utoronto.ca](mailto:bswd.grants@utoronto.ca) no later than the end of each term.

Student's Name:	
Student Number:	Type of Service:

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**Declaration (to be completed by service provider within Canada):**

I hereby declare that I am a **regulated** health care professional.

- My College/Regulatory Body is: \_\_\_\_\_.
- If one has been assigned, my registered member number is \_\_\_\_\_.

I understand that this information may be verified with the respective College/Regulatory Body for auditing purposes.

X \_\_\_\_\_

**Signature of service provider**

**Date**

Service Provider's Information	
Name:	Telephone Number:
Address:	
Email Address:	