ENCOUNTER REPORT

This is to verify that _____ provided _____ total encounters this

quarter and _____ encounters utilizing the sliding fee scale at _____
(approved service site)

for the service quarter beginning _____ and ending _____ .
(MM/DD/YY) (MM/DD/YY)

This signed and notarized form is due 10 business days after the last day of the completed quarter. The form shall be submitted to:

Arizona Loan Repayment Program Manager
Bureau of Health Systems Development and Oral Health
Arizona Department of Health Services
1740 West Adams Street, Room 205
Phoenix, Arizona 85007

I hereby verify I have provided these services.

_____ _____
Signature of Obligated Provider Date

State of Arizona)
)
County of)
The foregoing instrument was acknowledged before me this_____ day of_____ ,_____ ,

by_____ . My Commission Expires:_____
Notary Public

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I hereby verify that the above information is accurate.

_____ _____
Signature of Service Site Executive Director/Administrator Date
or authorized signatory

State of Arizona)
)
County of)
The foregoing instrument was acknowledged before me this_____day of_____ ,_____ ,

by_____ My Commission Expires:_____
Notary Public