

ENCOUNTER REPORT

This is to certify that _____ provided _____ total encounters of which _____ encounters utilized the approved sliding fee scale for the service quarter beginning _____ and ending _____ at the approved service site:
(MM/DD/YYYY) (MM/DD/YYYY)

(name of service site)

(complete address)

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 Department of Health Services
Bureau of Health Systems Development and Oral Health
J-1 Visa Waiver Program
1740 W. Adams, Room 205
Phoenix, Arizona 85007**

I hereby verify that 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

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