

**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)

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(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  
J-1 Visa Waiver Program  
1740 W. Adams, Room 205  
Phoenix, Arizona 85007**

I hereby verify that I have provided these services.

\_\_\_\_\_ Date \_\_\_\_\_  
(signature of obligated provider)

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