

ENCOUNTER REPORT

This is to certify that _____ provided _____ total encounters this
(Loan Repayment Recipient)
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 State Loan Repayment Program Manager
Bureau of Women's and Children's Health
Arizona Department of Health Services
150 N 18th Avenue Suite 320
Phoenix, Arizona 85007**

I hereby certify 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
or authorized signatory

Date

State of Arizona)
)
County of)

The foregoing instrument was acknowledged before me this _____ day of _____, _____,

by _____ My Commission Expires: _____
Notary Public