HEALTH CARE PROVIDER REPORT

Report Due: Monthly for the first 6 months of full compliance and then quarterly thereafter.

DOPL
ATTN: COMPLIANCE UNIT
PO BOX 146741
SALT LAKE CITY UT 84114-6741

Case #: _____

Name of Licensee: _____

Profession: _____

Dates Seen:_____

Frequency of Visits:_____

Were there any missed appointments?
❑ No ❑ Yes. How many?_____

Have you read the conditions of licensee's Contract/Order? ❑ Yes ❑ No. *If No, please read it before submitting this document.*

What are the major issues being addressed in treatment?_____

_____

Please list current medications:_____

_____

Please comment in detail on how the licensee is doing with regard to relevant issues. Include at least the following: recognition and insight into medical diagnosis, interaction during appointments and compliance with treatment to include medications: _____

_____

_____

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_____

Evaluation of Progress_____

_____

_____

Is Licensee in Compliance with Treatment Plan? ❑ Yes ❑ No

In your opinion, is Licensee safe to Practice?
❑ Yes ❑ No

_____
Name (*Please Print*) and Title

_____
Signature of Provider

(____) ____-_____
Phone Number

___/___/___
Date

This document may be uploaded to Affinity or submitted by FAX to (801) 530-6404.