# HEALTH CARE PROVIDER REPORT

**Report Due:** Monthly unless otherwise instructed.

**Please provide DOPL case number** ***(required)***

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

Case #*(found on stipulation)*: _____

Name of Licensee: _____

Profession: _____

Dates Seen:_____

Frequency of Visits:_____

Were there any missed appointments?

Yes ◯ No ◯ If yes, how many?_____

**Have you signed the MOU and read the conditions of licensee's Contract/Order? ◯ Yes**
***If No, please do so prior to 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: _____

_____

_____

_____

_____

_____

_____

_____

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*)

_____
Signature of Provider

(____) ____-_____
Phone Number

___/___/___
Date