HTCC Consultation Verification Form



Name:		Date:
CHT ID#:		
Setting Description:		
☐ Medical	☐ Health Club	☐ Athletic Team
☐ Industrial	☐ Business	☐ School
☐ Other		
Describe Consultation	Services:	
☐ Prevention Program	☐ Screening	☐ Medical Assessment & Intervention
□ Other		
submit the Client Services By signing below, I certify t and that I have personally representation of these ho accept further verification f For Self-Verification: In add because I am in private pra	Log with this document to hat the hours listed here as verified them for accuracy. urs may lead to penalties, if rom me. ition, I understand that if I actice, my inaccurate or false.	related to hand therapy. Please complete and support hours submitted. re true and correct to the best of my knowledge I am aware that my inaccurate or false ncluding, but not limited to, HTCC's refusal to am the CHT listed above and signing this form se representation of these hours may lead to enial of my certification, recertification, or
eligibility for certification.		
Signature		
Name		Title
Work Address		City/State/Province
Telephone/Ext.		Relationship to CHT





Instructions: Please record consultations provided with description and hours of service; total hours at bottom of page and submit with signed Consultation Verification Form.

Service Provided	Facility Name	Facility Contact	Date(s) of Service	Hours
Racquet analysis and recommendations for spa client	Woodbridge Health Club	Mary Smith	7/14/07	7
Consulted for two hrs/week for 20 weeks	ABC Company	Tom Miller	6/1/07-12/1/07	80
TOTAL HOURS THIS FORM:				