Clinical Log – FORM C

Name: _____   **Date: _____**

This form is to be filled out by Advanced Practice Providers and Allied Health Professionals

ALL 25 spaces must be completed with in-hospital patients from Kettering Health

IF YOU DO NOT SEE PATIENTS IN THE HOSPITAL, PLEASE COMPLETE FORM D TO CHANGE YOUR STATUS TO AHP ASSOCIATE

	Encounter Date	E-Number or Identifier	Procedure Code/Type of visit	Diagnosis	Location/Facility
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Maintain HIPAA Compliance – Please use the E# for each encounter