

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 _____

This form represents _____ hours in consultation related to hand therapy. Please complete and submit the Client Services Log with this document to support hours submitted.

By signing below, I certify that the hours listed here are true and correct to the best of my knowledge and that I have personally verified them for accuracy. I am aware that my inaccurate or false representation of these hours may lead to penalties, including, but not limited to, HTCC's refusal to accept further verification from me.

For Self-Verification: In addition, I understand that if I am the CHT listed above and signing this form because I am in private practice, my inaccurate or false representation of these hours may lead to penalties including, but not limited to, revocation or denial of my certification, recertification, or eligibility for certification.

Signature

Name

Title

Work Address

City/State/Province

Telephone/Ext.

Relationship to CHT

