Office: (616) 245-7327
Fax: (616) 245-1553
alcinterpreters@gmail.com

Associated Language Consultants

Interpreting, Translating and Teaching Services

880 Grandville Ave, Suite B
Grand Rapids, MI 49503-5049

REMINDER: Forms are **due** by the 5th of each month.

INTERPRETER VERIFICATION FORM

Date Service Provided:

_____-_____-_____

Patient/Client Name: _____ _____ Approval #: _____
(First Name) (Last Name) (# must be given by agency)

Additional
Patient/Client Name: _____ _____ Approval #: _____
(First Name) (Last Name) (# must be given by agency)

Appointment Address: _____ Suite #: _____

Consultant's Name: _____ Language: _____

TIME:

FROM_____ AM/PM TO_____ AM/PM = _____ Hour(s)

VERIFICATION SIGNATURE: _____ DATE: ____/____/____
(SIGNATURE REQUIRED FOR VERIFICATION)

RN/RD/SW/OTHER Name: _____

OBSERVATIONS AND COMMENTS

			Min from time of call		
Was the interpreter on time?	YES	NO	15-20	20-30	30-40
Was the interpreter knowledgeable?	YES	NO			
Are you satisfied with the services provided?	YES	NO			

Additional
Comments_____

_____

_____

We encourage you to make comments, this will allow us to provide you with the best possible service. Thank you.
*****NOTE:** All forms must be fully completed with verification signature and approval # for issuance of payment.

CONSULTANT'S USE ONLY

Mileage Incurred: Parking Cost:

_____ $_____

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OFFICE USE ONLY

Hour(s) Incurred: Costs Incurred:

_____ $_____