

**Washington Medicaid Reimbursement Program**

**Document Transmittal Form**

\_\_\_\_\_ School District

W \_\_\_\_\_

\_\_\_\_\_ Number of Audiology Professional Logs

\_\_\_\_\_ Number of Counseling Professional Logs

\_\_\_\_\_ Number of Nursing Professional Logs

\_\_\_\_\_ Number of OT Professional Logs

\_\_\_\_\_ Number of PT Professional Logs

\_\_\_\_\_ Number of Psychology Professional Logs

\_\_\_\_\_ Number of SLP Professional Logs

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign, date, and return this form to: **Leader Services, P.O. Box O, Hazleton, PA 18201.**



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