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.**