

## Quarterly Work Report

SHARP Program – Alaska Department of Health & Social Services

This report form is to be completed by each SHARP practitioner and his/her respective practice site (agency). The SHARP program must verify that each participant has been delivering primary care services at the specified practice site during the past quarter. Please confirm this by completing this form, signing and then sending it to SHARP program office.

### Reporting Period

<u>Quarter</u>	<u>End-date</u>	<u>Check one period</u>	<u>Report Due - NLT</u>
Jan-Mar	31-Mar		30-Apr
Apr-Jun	30-Jun		31-Jul
July-Sept	30-Sep		30-Oct
Oct-Dec	31-Dec		31-Jan

### Part 1: Practitioner Information

Practitioner Name			
Email & Phone number			
SHARP-authorized FTE-size	(check one)	Full-Time: <input type="checkbox"/>	Half-Time: <input type="checkbox"/>
Start-date (effective date)			
AK License number		Discipline & Specialty:	

If clinician served only a “partial-quarter” then: Start: \_\_\_\_\_ End: \_\_\_\_\_

During this report period, I as clinician practiced primary care at a total of \_\_\_\_\_ practice sites, as named below. If there were other practice site(s), then a full listing is provided.

Comment(s): \_\_\_\_\_

I certify by my signature below, as the here-listed SHARP practitioner, that all data contained in this report are accurate and can be substantiated by a record-review. I declare that I worked as a primary care clinician during the here-stated period, at the clinic site(s) listed below, and as in accordance with my SHARP contract, in either a “Full-Time” or a “Half-Time” capacity. I hereby certify, under penalty of revocation of my Alaska SHARP agreement, that I personally delivered the type of healthcare services for which my SHARP award was approved at the here-stated site(s), and further, that my practice is using a sliding fee scale or ‘no-pay’ policy for uninsured patients, as submitted with my SHARP application.

_____ Practitioner's Signature	_____ Date
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