RAINBOW TREATMEN CENTER COVERSHEET/SIGN-IN SHEET

FACILITATOR NAME: _____

PROGRAM: OTHER

☐ **IN PERSON** ☐ **TELEHEALTH**

(For Groups ONLY, Enter Information Below)
DOS: _____ **BEG TIME:** _____ **END TIME:** _____

GROUP NAME (ON SCHEDULE): _____
☐ **CAREER** ☐ **WELLNESS** ☐ **CBQ** ☐ **W/R** ☐ **ADWC**

IS GROUP CANCELLED? ☐ **REASON:** OTHER

NON-GROUP DOS: _____

NAME OF INDIVIDUAL OR ADDITIONAL NOTES: _____

NAME OF PARTICIPANT:	BEG. TIME:	END TIME:	TYPE OF SERVICE: *(USE DROP DOWN MENU)*
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER
			OTHER

BELOW THIS LINE IS FOR BILLING DEPARTMENT USE ONLY

DATE/INIT RECEIVED: _____ **DATE/INIT APPROVED:** _____ **NUMBER OF NOTES:** _____

DATE/INIT RETURNED: _____ **INITIALS:** ____