

# Cross Cultural Communications

PO Box 2166 ~ Sumner, WA 98390

Office: 253-447-2000 or 800-893-5258

Fax: 253-447-2041 or 999-918-8524

www.crossculturalcom.us

Mon-Fri 7 am – 8 pm ~ Sat 8 am – 2 pm

Call these #'s below during **Non-Office Hours!**

Pager: 253-207-4694 or

Cell: 253-227-2713

## INTERPRETER ENCOUNTER FORM

<b>CCC Job#</b>	
---------------------	--

### APPOINTMENT INFORMATION

1. Client Full Name (Last Name, First Name, Middle Initial)						2. Date Requested				
3. Client Phone (      )		4. Language Requested		5. Date of Birth		6. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		7. Requester Name		
8. Appointment Address (Number, Street, City, Zip Code)						9. Requester Phone				
10. Provider Name:						11. Cost Center: Name                      Number				
12. Department			13. Doctor's Name			Service Type Requested <input type="checkbox"/> Social Service <input type="checkbox"/> Medical				
						Scheduled Start Time:		Anticipated End Time:		
14. L & I # (If Applicable)		15. Date of Injury		16. <b>NO SHOWS</b> <b>Check One Only</b>		Patient <input type="checkbox"/>	Provider <input type="checkbox"/>	Interpreter <input type="checkbox"/>	Cancelled <input type="checkbox"/>	Rescheduled <input type="checkbox"/>

### THE SECTION BELOW TO BE COMPLETED BY THE INTERPRETER

17. Print Full Name of Interpreter Providing Service (Last Name, First Name, Middle Initial)		
18. Origin (Address, City, State)		19. Destination Address
20. Final Destination Address (If Applicable, <b>Must</b> include copy of <b>MapQuest</b> for verification)		
21. Mileage to Appointment (If Applicable)		22. Mileage From Appointment (If Applicable)
		23. Total Reimbursable Mileage
24. Date of Service		25. Total Billing Time
<b>26. Interpreter's Certification</b> I hereby certify under penalty of perjury that the information and charges listed herein for services rendered are accurate and have been provided as authorized and without discrimination on the grounds of race, creed, color, national origin, or sex.		
Interpreter Signature		Date

### THE SECTION BELOW TO BE COMPLETED BY THE REQUESTOR – OR MEDICAL PROVIDER

27. Service Date		28. Interpreter Arrival Time		<b>O</b>	Phone Interpretation		<u>Staff Initials</u>		Picture ID		<u>Staff Initials</u>	
				<b>R</b>					Verified			
29. Service Start Time / <u>Staff Initials</u>						30. Service Completion Time / <u>Staff Initials</u>						
31. Was the interpreter service completed? <input type="checkbox"/> Yes <input type="checkbox"/> No    If No, explain in comments section												
<b>32. Requestor – Staff/ Medical Provider Certification</b> <b>DO NOT SIGN BELOW UNTIL ALL ITEMS ABOVE ARE COMPLETED AND REVIEWED FOR ACCURACY.</b> Use <b>Box 35</b> as needed.												
Signature						Date						
33. PRINT NAME HERE						34. TITLE/POSITION						
35. COMMENTS												

Available 24 hrs a day 7 days a week!