SWEDISH BACK UP DOCUMENTATION FORM

Vendor / Agency Name:_____

Interpreter Name (print):_____

Date of Assignment:_____ Job Number:_____

Patient Name:_____

Location / Campus:_____ Department Name:_____

Back up documentation for assignment greater than three (3) hours must be filled out per one hour increments and Provider must verify medical activity and continued need for interpretation by providing provider name and signatures for each hour increments. Please Note: Interpreters may not work more than twelve (12) hours total for each patient

Time:		**Medical Activity / Interpretation Summary:**	**Provider Name (print)**	**Provider Signature**