



341 South Third Street, Suite 300
Columbus, Ohio 43215
Telephone: 614-899-6666
Telefax: 614-899-9200
info@access2interpreters.com

Corporate member of the ATA

www.access2interpreters.com

Job# _____

Interpreter's Name: _____

Staff making referral: _____
Date referral received: _____ Phone: _____
Department: _____
Purchase Order: _____ Case (Claim) Number: _____
Date & Time Services Needed: _____
Language: _____
Patient's Name: _____ DOB: _____
Location: _____ Procedure: _____

MEDICAL CENTER/COURT/SOCIAL AGENCY STAFF VERIFICATION:	
Time In: _____ am/pm	Time Out: _____ am/pm
Verified By: _____	Verified By: _____
Ext: _____	Ext: _____
Printed Name: _____	Printed Name: _____

Note: Staff must initial for each 3 hour period:

Time:	Time:	Time:
OK'd by & Ext:	OK'd by & Ext:	OK'd by & Ext:

Please complete if the interpreter leaves and returns:

Time Out: _____ am/pm	Time In: _____ am/pm
Verified By: _____	Ext: _____

**SIGNATURE OF STAFF REQUIRED
INTERPRETER MUST SUBMIT THIS FORM TO
ACCESS 2 INTERPRETERS, LLC FOR REIMBURSEMENT**