S.A.A.C.

SOUTHEAST ASIAN ASSISTANCE CENTER

A Culturally Competent Healthcare Interpreting Agency

Submision Date:_____

Recorded Date: _____

Recorded By: _____

Fee For Services -Interpreting Assignment Sheet				
Requested on:	**Req. Language**	**D.O.S.**	**Requesting Agency**	**Contact Person**
Date: _____ **Time:** _____				**Name:**_____ **Tel. No. ( )**_____

CLIENT/PATIENT'S INFORMATION				
Last Name	**First Name**	**D.O.B.**	**Med. Record / Client No.**	**Contact Information**

APPOINTMENT DETAILS			
Appointment Address	**Department/Provider's name**	**Appointment Type**	**Estimated Time**

Apt Time:	Start Time	Finish Time	Total Time	Cancelled (Y/N)	No Show (Y/N)	Travel Time R/T in Minutes	Miles Round Trip (Record only if more than 10 Miles)

The Interpreter identified below provided services as indicated herein:			
Interpreter's Name	***Interpreter's Signature***	***Language***	***Date***
Provider's Name	**Provider Title**	**Finish Time**	**Provider Signature**

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