Maryland
DEPARTMENT OF HEALTH

MDC-LARP Monthly Report Sheet

Name: _____   Date: _____

Phone: _____

Email: _____

<u>Instructions</u>: Only one report sheet should be submitted per month. If you practice at multiple locations, please combine all information on one report.

JANUARY – 2024		Hours Worked/Week	#Medicaid Appts/Week **SCHEDULED**	#Medicaid Appts/Week **COMPLETED**	Total # Patients/Week
01/01/24	01/06/24				
01/07/24	01/13/24				
01/14/24	01/20/24				
01/21/24	01/27/24				
01/28/24	01/31/24				

_____
Authorized By

_____
Title

_____
Date

PLEASE COMPLETE AND EMAIL BY FEBRUARY 10, 2024.

THANK YOU!

EMAIL TO: mdh.mdclarpprogram@maryland.gov

☐   Please check here to confirm that all information provided is complete and accurate.
Note: This box must be checked for this report to be accepted.