PATIENT LOG

Name: _____ APCA ID Number: _____

Year Performed	Type of Study/Examination/Procedure	Level of Involvement (Performed/Interpreted/ Reported)	Facility Name	Facility Address	Facility Phone Number

Please retain this form for at least 3 years following your application submission date. In case of application audit, APCA may request the interpreting/reporting physician's name and contact information and/or images without patient identifying information in conformity with the Health Insurance Portability and Accountability Act (HIPAA).