Medicaid Technical Assistance & Policy Program  
(MedTAPP)  
Service Hours Verification Form

**Section 1** – *To be completed by the MedTAPP recipient*

Name:
___________________________________________________________________

Medical School Graduation Year:
___________________________________________________________________

Name & Address of the Site Where You Provided Service:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Briefly describe the type of work you have performed at this site:
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

*Please attach a log of dates and hours if you have several instances of service at the same site.*

Signature and Date:
___________________________________________________________________
Section 2 – To be completed by a representative at the service site

Name and Address of the Site:

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Does this institution qualify as a high-volume Medicaid site (a site that sees no less than 30% Medicaid patients)?

_____ Yes  _____  No

Name, Title, and Signature of the Authorizing Official Completing this Form

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

The second page of this document is to be completed by an authorized individual at the employing institution.