Bandon SD	Brookings SD	Gold Beach SD	Coos Bay SD	Coquille SD
Myrtle Point SD	North Bend SD	Port-Orford SD	Powers SD	Reedsport SD

Medicaid Service Log

For month of ______________________________

Last Name: ___________________________________ First Name: ____

Birth Date: ___________________________________ Medicaid ID#: ____

Service Provider: _____________________________ Credentials: ____

Resident District: _____________________________ Attending School: ____

ICD 10 code: _____________ **Procedure code:** ___________

DATE	START/STOP TIME	DEVIATIONS	TOTAL TIME (MINUTES)	RN INITIALS	DATE	START/STOP TIME	DEVIATIONS	TOTAL TIME (MINUTES)	RN INITIALS

SIGNATURES OF NURSES:

Printed Name	Signature/ Credentials
1.______________________________	______________________________
2.______________________________	______________________________

Revised 9/2019