



## Well-Ahead Louisiana Primary Care Office

### Louisiana Conrad 30/J-1 Visa Waiver Program

#### Quarterly Service Report: Forensic Pathology

Please return this report to:

[PCRH@la.gov](mailto:PCRH@la.gov)

Bienville Building, 628 North 4<sup>th</sup> Street, Bin #15, Baton Rouge, LA 70802

PO Box 3118, Baton Rouge, LA 70821-3118

Phone: 225-342-9306 Fax: 225-342-5839

Physician:	Medicaid ID #:	Louisiana License #:
Home Address:	Practice Name and Address:	Start Work Date:
E-mail Address:	Practice Telephone Number:	Practice Fax Number:

For services rendered (check one): Year: ___ 2019 ___ 2020 ___ 2021 ___ 2022 ___ 2023 ___ 2024 ___ 2025 Quarter: ___ January 1-March 31 ___ April 1-June 30 ___ July 1-September 30 ___ October 1-December 31	
Number of clinical autopsy hours performed this quarter:	Number of forensic autopsy hours performed this quarter:
Number of hours providing court testimonials this quarter:	Number of hours performing out-of-parish/state autopsies: Out-of-Parish: Out-of-State:
If hours are less than 40 hours per week, 32 clinical hours per week, please explain:	
<b>Patient Profile Statistics (Complete each item and indicate ACTUAL or ESTIMATED)</b>	
Total number of autopsies performed this quarter:	
Clinical:	Forensic:
Out-of-parish:	Out-of-state:
Did this practice site outsource any autopsies for the prior year? ___ Yes ___ No If <u>yes</u> , how many and specify location:	
Other employment/moonlighting done this quarter, if any:	

<b>Complete on your last report:</b> Are you staying at this practice site? ___ Yes ___ No If <u>no</u> , where do you plan to go? Please provide contact information if you plan to leave.		
I verify that the physician named has maintained a full-time practice at the facility listed and that all medical practice has been provided in the appropriate designated HPSA(s).		
Physician Signature:	Employer Signature and Title:	
Date:	Date:	
LDH Use:	Date Received:	Date Entered: