INDEX AND VERIFICATION FORM

Case#	Patient#	Diagnosis	Page#
1	1		
2	2		
3	3		
4	4		
5	5		
6	6		
7	7		
8	8		
9	9		
10	10		

The above listed cases were performed by Dr._____ at this facility.

_____

Name of Office Manager (PLEASE PRINT)

_____ _____

Office Manager Signature **Notary Public Signature**

_____ _____

Title **Commission Expires**

Notary Seal:

Date:_____

INDEX AND VERIFICATION FORM

Case#	Patient#	Date of Service	Diagnosis	Page#
1	1			
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4	4			
5	5			
6	6			
7	7			
8	8			
9	9			
10	10			

The above listed patient numbers were performed by Doctor _____ at this facility.

_____

Name of Hospital Administrator (PLEASE PRINT)

_____ _____

Hospital Administrator Signature **Notary Public Signature**

_____ _____

Title **Commission Expires**

_____

Date **Notary Seal**

s:BOC/index and verification form (revised 1/7/05)

This Index and Verification Form for case reports must be completed. The hospital administrator must verify that you were the physician treating the patient in each case on the date stated. If more than one hospital, submit a separate Index for each one.

DO NOT INCLUDE THE FOLLOWING IN YOUR ACTUAL CASE REPORTS:

- **Hospital Name or Office Name**
- **Name or Initials of Patients**
- **Medical Record Numbers**
- **Full Face Photographic Images**
- **Age Information of Patient if Over 89**