MIDWIFE SONOGRAPHY PATIENT LOG

APPLICANT: ______________________________________ ARDMS NUMBER: ______________________

No.	Year Performed	Type of Study	Facility Name	Facility Address	Facility Phone Number
Sample	*2011*	*Third Trimester*	*Midwifery Clinic*	*451 Junction Rd. Madison, WI 53717*	*(800) 323-8942*
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Do not mail this form with the application. Please maintain this form for at least 36 months following your application submission date. In case of application audit, you may be requested to provide additional information and/or images without patient identifying information in conformity with the Health Insurance Portability and Accountability Act (HIPAA).

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