MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF GENERAL COUNSEL

VOLUNTEER HEALTH SERVICES ACT
SPONSORING ORGANIZATION QUARTERLY REPORT

SPONSORING ORGANIZATION INFORMATION

ORGANIZATION NAME		
ORGANIZATION CONTACT PERSON	ORGANIZATION CONTACT PERSON EMAIL	
ORGANIZATION TELEPHONE NUMBER	COUNTY	
ORGANIZATION STREET ADDRESS	CITY, STATE	ZIP CODE

QUARTER OF REPORTED SERVICE (check the appropriate quarter and fill in year)

☐ January - March Year _____ (Q1)	☐ April - June Year _____ (Q2)
☐ July - September Year _____ (Q3)	☐ October - December Year _____ (Q4)

Name (as it appears on license or certificate)	Date of Birth (MM/DD/YYYY)	Health Care Profession (i.e., physician, nurse, dentist, surgeon, etc.)	License of Certificate Number	State of Issuance

SIGNATURE OF SUBMITTING ORGANIZATION PRINCIPAL OFFICIAL

	DATE

Return completed form to:	Missouri Department of Health and Senior Services Attn: Office of General Counsel P.O. Box 570 Jefferson City, MO 65102-0570 Fax: 573/751-0247 Email: VHSA@health.mo.gov	**DATE STAMP RECEIVED**