Form Approved
OMB No. 0990-
Exp. Date XX/XX/20XX

# SERVICE DELIVERY FORM
# TSU PATIENT CENTERED CARE COLLABORATION TO IMPROVE MINORITY HEALTH (PCCC) INITIATIVE

Directions: Complete this form at the end of post-intervention home visit. Pharmacist will send the completed form to the program coordinator.

Patient Name: ______________________

Pharmacist Name: _________________________________

Post-Intervention Visit Date: _________________________

Patient Signature: ___________________ Date: ___________________

Pharmacist Signature: ________________ Date: ___________________

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0990- . The time required to complete this information collection is estimated to average (hours)(minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 336-E, Washington D.C. 20201, Attention: PRA Reports Clearance Officer