



PROFESSIONAL LIABILITY ASSOCIATION, INC.
RISK RETENTION GROUP, INC.

Outpatient Visit Audit Form

Insured: _____ Effective Date: _____

Policy #: _____ Expiration Date: _____

Audit Period Dates: _____ to _____

Number of Urgent Care Visits _____

Number of ER Visits _____

Number of Occupational Medicine Visits _____

I certify that the information given above is true and correct to the best of my knowledge and belief.

Signature: _____

Printed Name: _____

Title: _____

Date: _____