ARIZONA DEPARTMENT OF CORRECTIONS
HOSPTIALIZATION CENSUS STATEWIDE REPORT

CONTRACTOR NAME: _____

Month and Year: _____ Date Submitted: _____

Please provide following information on each inmate admitted to a licensed health care institution (hospital, nursing home, hospice, etc)

Inmate Name	Inmate ADC Number	Arizona State Prison Complex Sending Inmate	Admission Date	Discharge Date	Hospital/Health Care Institution Name	Problem	Daily Notes, N	ICD #	Estimated Costs