

**LOCUM TENENS TIMESHEET**

Hospital or Group Name \_\_\_\_\_

Provider Name: \_\_\_\_\_

Date: Mon- Sun	(mm/dd)	Regular Hours (In/Out)	Overtime (In/Out)	On Call	Callback (In/Out)	Holiday (In/Out)	Mileage
				Y/N			
				Y/N			
				Y/N			
				Y/N			
				Y/N			
				Y/N			
				Y/N			

Provider Signature \_\_\_\_\_

Date \_\_\_\_\_

By my signature above, I confirm that all required documentation is complete, including medical records and insurance forms.

**\*\*\*\*Timesheets must be submitted each week by Tuesday at noon.\*\*\*\***

Client Authorizing Signature \_\_\_\_\_

Date \_\_\_\_\_

By my signature above, I confirm that all required documentation is complete, including medical records and insurance forms.



Fax (248) 357-3745

Voice (248) 357-1426