REHAB ALTERNATIVES

WEEKLY TIME SHEET

NAME (FIRST, LAST) _____ DISCIPLINE _____

FACILITY _____ PERIOD ____/____/____ **TO** ____/____/____

DATE	TIME IN	TIME OUT	LUNCH	HOURS
SUNDAY ____/____/____				
MONDAY ____/____/____				
TUESDAY ____/____/____				
WEDNESDAY ____/____/____				
THURSDAY ____/____/____				
FRIDAY ____/____/____				
SATURDAY ____/____/____				

TOTAL HOURS _____

_____
CLINICIAN SIGNATURE

_____
AUTHORIZED SIGNATURE

_____
DATE

_____
DATE

SIGNING THIS DOCUMENT CERTIFIES THAT ALL ABOVE INFORMATION IS ACCURATE AND TRUTHFUL.

WEEKLY TIME SHEET DUE MONDAY BY 4:00PM FOR THE PRIOR WEEK.

TIME SHEETS AVAILABLE ONLINE & FILLABLE AS PDF.

FACILITY ACKNOWLEDGES THAT REHAB ALTERNATIVES, PLLC IS NOT AN EMPLOYER. CLINICIANS ARE ASSIGNED TO THE FACILITY TO RENDER CONTRACTED SERVICES AND SHALL NOT BE EMPLOYED BY THE FACILITY. FACILITY SHALL NOT RETAIN OR ATTEMPT TO RETAIN ANY CLINICIAN WHO PROVIDES SERVICES TO FACILITY PER THE TERMS OF REHAB ALTERNATIVES SERVICE AGREEMENT.

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