



## WEEKLY TIMESHEET

**Please Fax To: 1-(414)-858-2400    By: Monday 9:00 am**

Physician Name: \_\_\_\_\_

Assignment Dates: \_\_\_\_\_

Client: \_\_\_\_\_

Client Contact: \_\_\_\_\_

Facility: \_\_\_\_\_

Department: Radiology

DAY	START TIME	END TIME	OVERTIME HRS.	ON-CALL	ADD. CALL HRS.	TOTAL HOURS
Monday				Y / N		
Tuesday				Y / N		
Wednesday				Y / N		
Thursday				Y / N		
Friday				Y / N		
Saturday				Y / N		
Sunday				Y / N		
<b>Weekly Totals:</b>						

**REIMBURSEMENTS:**

1. Mileage. \_\_\_\_\_ # of Miles @ \$.\_\_\_\_\_ per mile.

2. Other (lodging, rental car, airfare):

\_\_\_\_\_

**(Please submit a copy of all receipts that apply).**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_