



WEEKLY TIMESHEET

Please submit at the end of your assignment to:

Fax: 1-(414)-858-2400 or Email: april@bhpdoctors.com

Physician Name: _____ Shift Dates: _____

Client: _____ Client Contact: _____

Facility: _____ Department: _____

| WEEKDAY & DATE | START TIME | END TIME | OVERTIME HOURS | ON- CALL | ADD. CALL HRS. | HOLIDAY RATE/SPECIAL RATE | TOTAL HOURS |
|---------------------------|---------------|-------------|-------------------|-------------|----------------------|---------------------------------|----------------|
| Monday | | | | Y / N | | | |
| Tuesday | | | | Y / N | | | |
| Wednesday | | | | Y / N | | | |
| Thursday | | | | Y / N | | | |
| Friday | | | | Y / N | | | |
| Saturday | | | | Y / N | | | |
| Sunday | | | | Y / N | | | |
| Weekly Totals: | | | | | | | |

REIMBURSEMENTS:

Mileage: _____ # of Miles @ \$. _____ per mile.

Other: _____
 (Please list above and submit a copy of all receipts that apply, i.e. lodging, rental car, airfare)

Physician Signature: _____ Date: _____

Client Signature: _____ Date: _____