



## Provider Assignment Record

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

Facility Name \_\_\_\_\_

Total Mileage \_\_\_\_\_

Day	Date	Unit	In	Break	Out	Total Hrs	Provider Signature
			am		am		
			pm		pm		

Client Signature (In Time) \_\_\_\_\_  
(Signature)

Client Print Name (In Time) \_\_\_\_\_  
(Print Name)

Client Signature (Out Time) \_\_\_\_\_  
(Signature)

Client Print Name (Out Time) \_\_\_\_\_  
(Print Name)

**Agreement:** The individual above acknowledges that he/she is able to verify the hours worked by Provider and agrees that the time stated is correct. Work logs must be completely filled out, legible, and free of any edits in order to be approved. All provider work logs received before 1 pm CT will be reviewed and approved for payment by close of business Monday - Friday.



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