LexxHealthcare

Work Record

Provider Name & Specialty: _____

Client Name: _____

Date	Day	On Call	Start Time	End Time	Regular	Overtime	Total Patient Contact	Total Hours
	MON	☐Yes ☐No						
	TUES	☐Yes ☐No						
	WED	☐Yes ☐No						
	THURS	☐Yes ☐No						
	FRI	☐Yes ☐No						
	SAT	☐Yes ☐No						
	SUN	☐Yes ☐No						
				TOTALS:				

SIGNATURES REQUIRED

Provider Signature: _____ Date: _____

*Provider : By signing this work record, you warrant that the hours reported above represent the time worked for the designated client under an independent contractor relationship.

Mail Check To (check one): Home or Other _____

Client Signature: _____ Date: _____

CLIENT: By signing this work record, you agree with the hours worked indicated above and you will be invoiced accordingly. If you have *any* questions *or* concerns, please contact your consultant at 888-440-8111.

Mileage and Tolls Log: *when driving your OWN car only, Not a rental car*				
Date:	From City:	To City:	# of Miles:	Daily Tolls:

Please FAX to **888-343-6947** no later than Monday 12:00 Noon *(Eastern Standard Time)*

210 N.University Drive, Suite 902, Coral Springs, FL 33071 P 888-440-8111 F 888-343-6947

www.lexxhealth.com