Childhood Autism Treatment Team / Childhood Autism Therapies - Timesheet 2017

Client Name:

Therapy Month: | Senior Completes last three columns

Therapist Name (signature)	Work Date	Time In	Time Out	Hours Worked	Travel Hours (senior only)	Staffing Code (PM, FG, TM. Blank = BT)	Monthly Total Direct Hours (no travel)

Employee Signature	(Total Hrs for Month)	

Senior Staff: Collect, Validate Data, &

Submit monthly by 5th of next month

Scan/Photo+Email to: cryan12@msn.com

text msg to 262-370-5527 or fax to 262-495-8689. or Mail to: Colleen Ryan,

N1563 County Rd H, Palmyra WI 53156

(Contact Mike R. 262-370-5527 with any issues)

Family/Guardian Signature: | **Date:**