

Provider Name: _____

Facility: _____

My recruiter is: _____

Provider Type (select one): Physician Midlevel

Other: _____

Day of the Week	Date	Start Time	End Time	Total Hours
SUNDAY	/ /	:	:	
MONDAY	/ /	:	:	
TUESDAY	/ /	:	:	
WEDNESDAY	/ /	:	:	
THURSDAY	/ /	:	:	
FRIDAY	/ /	:	:	
SATURDAY	/ /	:	:	
TOTAL				0

CHECK ONE
<input type="checkbox"/> Direct Deposit
<input type="checkbox"/> Manual Check

Mileage and Expense Log (mileage is only reimbursed when using your own vehicle and does not apply to a rental car)			
Date	From	To	No. of Miles
/ /			
/ /			
/ /			
/ /			
/ /			
/ /			
/ /			
TOTAL			

Other reimbursable out-of-pocket expenses (legible receipts must accompany this form for reimbursement)			
PLEASE NOTE: Any additional products or services purchased (e.g. GPS, additional insurance, satellite radio, etc.) are not covered by SBG Healthcare, and are the responsibility of the provider.			
Date	Type	Description	Amount
/ /			\$
/ /			\$
/ /			\$
/ /			\$
/ /			\$
/ /			\$
TOTAL			

REQUIRED SIGNATURES	
Provider Name (Print): _____	Title: _____
Provider Signature: _____	Date: ____ / ____ / ____
*Provider: By signing this, I confirm that the hours and expenses reported here are true and correct and that these hours and expenses will be reviewed and paid in accordance as an independent contractor. I also understand that receipts must be processed at the same time as the shifts they apply to. If a dollar amount is included on the timesheet and no receipt provided I agree that I am forfeiting the right to reimbursement for that expense.	

Client Name (Print): _____	Title: _____
Client Signature: _____	Date: ____ / ____ / ____
* Client: By signing this, I confirm that the hours and expenses reported here are true and correct and understand that these hours and expenses will be reviewed and billed in accordance with agreed upon terms. Please call your client manager if there are any questions.	

PLEASE FAX SIGNED FORM TO 305.999.6241 EACH MONDAY NO LATER THAN NOON (EST)