HOURLY TIME SHEET

Therapist:_____ Month:_____

☐OT ☐PT ☐SP ☐PTA ☐COTA
☐SEIT ☐ AIDE ☐ OTHER_____
Location of Service:_____
Budget Code:_____
(Nassau BOCES Only)

CHECK ONE:
- ☐ 1st thru 15th
- ☐ 16th thru 30th
- ☐ last day of service

DAY OF WEEK	DATE	MORNING IN	MORNING OUT	AFTERNOON IN	AFTERNOON OUT	TOTAL HOURS EXCLUDING LUNCH

I hereby certify this report is accurate:

Total Hours:_____ Therapist signature:_____ Date:_____
(must be to nearest ¼ hour)

Authorization Signature:_____Date:_____

Print Name:_____

All bills MUST uploaded through the NYTPS website by the 4th of the following month.