TIME SHEET

County Therapy Associates, LLC

Month _____

Year _____

Location _____

Name _____

Date	Time In	Time Out	Time for Lunch	Comments	Billable Hours	Facility Supervisor Signature

Associate Signature _____

Total Billable Hours: _____

Make (2) copies. Send (1) to *CTA* by the end of pay period, (1) to the facility, and (1) for your records.

PO Box 169 Whiteford, MD 21160 Fax (866) 593-9901