

**THERAPY**  
**Time Sheet**

EMPLOYEE NAME: \_\_\_\_\_ PATIENT'S NAME: \_\_\_\_\_

DATE	TIME IN	TIME OUT	SKILL	PATIENT'S SIGNATURE

I certify that this First Health Systems employee has provided the recorded services. (Patient's Initial) \_\_\_\_\_

First Health Systems, will not be responsible for hours worked if they are not signed off by a patient.