

PHYSICIAN SERVICES MONTHLY TIMESHEET

Physician: _____ **Hospital:** _____

Position: _____ **Department:** _____

Month/Year: _____

Please submit this timesheet to Nancy Arenas, Hospital Administration, at the end of each month for the CFO's and CEO's review. Pursuant to the provisions of the agreement, payment will not be made until a satisfactory timesheet has been prepared, submitted and approved by the Hospital and UHS.

Print / Type Form

Date	Activity / Event	Time
	Total	

I verify that this timesheet accurately records the time and services rendered to The George Washington University Hospital.

Physician Signature

Date

For Hospital:

To the best of my knowledge and belief, this timesheet accurately reflects the time and services provided to The George Washington University Hospital.

CFO Signature

CEO Signature