BURGER REHABILITATION SYSTEMS, INC.

OCCUPATIONAL THERAPY TIMESHEET
"A" FACILITY

EMPLOYEE: _____ DATE: _____

EMPLOYEE Reference # for **FAC #** column below	ARRIVAL TIME	DEPART TIME	TIME AT FACILITY		MIN. OF SERVICE CHG	MIN. OF SERVICE NCHG	TRAVEL TIME	MILES
1.			HRS	MIN				
2.			HRS	MIN				
3.			HRS	MIN				
4.			HRS	MIN				
5.			HRS	MIN				
SUBTOTALS								

LUNCH TAKEN: _____ TO _____

MARK IF YOU **DO NOT** GET YOUR BREAK: ☐ BREAK #1 ☐ BREAK #2

FAX TO **1(800) 490-5626** OR **(916) 983-5924**

TIME AT FACILITY		**TRAVEL**		**TOTAL TIME**
	+		**=**	

FACILITY #	**RESIDENT** LAST NAME, FIRST NAME	EVAL ✓	FREQUENCY	PAYER	EXPECTED MINUTES	**97003** EVALUATION	**97112** THERAPEUTIC EX.	**97140** NEURO. RE-ED	**97150** MANUAL THERAPY	**97530** GROUP THERAPY	**97530** KINETIC ACT.	**97535** ADL MANAGEMENT	**97542** WHEELCHAIR MGMT	**97760** ORTHOTIC FIT/TRNG.	**97761** PROSTHETIC TRNG.	**97762** C/O ORTHO/PROS USE	**OTHER** (CPT #)	**TOTAL MINUTES**

REMARKS

I ATTEST, UNDER PENALTY OF PERJURY, THE INFORMATION ON THIS TIME SHEET IS ACCURATE AND TRUE. I HAVE TAKEN ALL MEAL AND REST PERIODS UNLESS OTHERWISE NOTED BY ME ON THIS TIME SHEET.

SIGNATURE _____ DATE _____