Provider Monthly Hours

Month/Year: ____________________ Name of Provider: _________________

Day	Time In	Time Out	Total Hours
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			
31			
Additional hours used for programming or to meet/maintain accreditation standards (please specify): ____________ ____________			(Max. 8 hours)
TOTAL HOURS:			

Provider : ________________________ Agency Representative: _________________________

January 2017