



APC Work Log

Email to Kristina_Burke@dystaffing.com; fax: 888-864-0024

OFFICE USE ONLY:

Clinician #: _____

Assign. #: _____

Specialty: _____

*Client approved work logs are due by **8:00 am CT each Monday***

Clinician Name: _____ Week Ending: _____

Worksite: _____

DATES WORKED:	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	TOTAL
<i>Worksites -IF MULTIPLE, note facility per day worked</i>								
ACTUAL HOURS WORKED								
Start Time:								
End Time:								
<i>Time taken for meal period</i>								
Total Actual Hours Worked								

Note: *If a guarantee of weekly hours worked is reflected on the assignment confirmation document, the guarantee is not applicable in weeks if a holiday occurs or for any hours not worked by the clinician due to requested personal time off.*

Please ensure that any hours worked beyond your shift are approved² by the client and provide explanation below:

D&Y Clinician Signature

Client Representative Approval Signature

D&Y Clinician (PLEASE PRINT NAME)

Client Representative (PLEASE PRINT NAME)

Clinician and client signatures are required