

# TRADITIONS BEHAVIORAL HEALTH

## TIME ALLOCATION FORM

Week Ending Date (Friday): \_\_\_\_\_

Doctor Name: \_\_\_\_\_

Facility: \_\_\_\_\_

*Indicate the amount of time spent under each appropriate category:*

Day	Date	Patient Care	Non-Billable Patient Care	Training	Admin	Paid Time Off (PTO)	Total Time Spent
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
	<b>TOTALS:</b>						

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Doctor Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Administrator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Please submit completed and approved form to TBH Accounting Office at the end of each week:*

**FAX: (707) 258-0910**