MatchMakerAnesthesia, LLC

Email: marnie@matchmakeranesthesia.com
Fax: 1-888-818-8754

Name of Independent Contractor:_____

Date Submitted:_____

Name of Company (if applicable):_____

EIN of Company:_____

Facility Contracted With:_____

TIME LOG

Date	Facility Worked	Day	Contract Hours		Hours Exceeding Contract		Call Shift	Call Back Hours		Total Contract Hours	Total OT Hours
			Start	End	Start	End	WN/WE	Start	End		
Weekly Totals											

Expense			Dollar Amount
Airfare (Coach class equivalent)			
Car Rental (Mid-size equivalent)			
Hotel (Room rate and taxes only)			
Mileage		X.58.5/mi	
Meals			
Miscellaneous			
Expense Total:			

*****Expenses are only reimbursed as per contract*****

*****Receipts are required for expense reimbursement*****

Comments:

Please explain any miscellaneous expenses in comment section.

**Provider acknowledges and agrees that accurate timekeeping by the Provider is vital to the operation of MatchMakerAnesthesia, LLC. Provider agrees that he/she shall be solely responsible for timely submitting accurate timesheets to MatchMakerAnesthesia, LLC documenting the time he/she has dedicated to various procedures and consultations. Provider hereby acknowledges that his/her failure to timely submit accurate timesheets to MatchMakerAnesthesia, LLC may result in delayed payment of Provider's compensation for that pay period until accurate timesheets are resubmitted to and accepted by MatchMakerAnesthesia, LLC.*

Independent Contractor **Signature**:_____ Print name:_____

Department Director Signature:_____ **Print name:**_____

*Must be Signed By Staff Member at the Facility