**MONTHLY TIME DOCUMENTATION- MEDICAL DIRECTOR SERVICES**

Month/Year:_____

Position:_____ Minimum Monthly Hour Requirement:_____

Physician's Name:_____

| Date | Description of Activity | Time Spent |
|---|---|---|
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| | | |
| | **TOTAL:** | |

I certify the above is an accurate list of services provided and time spent in my position as Medical Director.

Physician Signature: _____ Date:_____

Signature of Department Director:_____ Date:_____

This material is intended for educational and informational purposes only. This document is not intended to be legal advice and is only an example for educational purposes. Legal advice must be tailored to the specific circumstances and users are responsible for obtaining such advice from their counsel.