  
  **Contract Services Time Sheet  
~Anesthesia Partners of Montana~  
St. Vincent Healthcare**

|  |  |
| --- | --- |
| **Contractor Name:** Carl Jay Gutierrez, **MD**  - | **For Dates:**   * **Month:** * **Year:   Date Submitted:** |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day** | **Date** | **Off** | **Regular** | | **On Call** | **Overtime** | | **Callback** | | **Regular Hours** | **OT Hours** | **Total Hours** |
| **In** | **Out** | **In** | **Out** | **In** | **Out** |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| **M** |  | N | 07/800 | 15/630 | N |  |  |  |  | 8 |  |  |
| **T** |  | N | 0700 | 1530 | N |  |  |  |  | 8 |  |  |
| **W** |  | N | 0700 | 1530 | N |  |  |  |  | 8 |  |  |
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| **F** |  | N | 0700 | 1530 | N |  |  |  |  | 8 |  |  |
| **S** |  | Y |  |  | N |  |  |  |  |  |  |  |
| **S** |  | Y |  |  | N |  |  |  |  |  |  |  |
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| **Totals** **Regular Days: \_\_\_\_\_\_\_  Overtime Hrs: \_\_\_\_\_\_\_ Contractor Signature: Auto Rental: \_\_\_\_\_\_\_  (Receipt enclosed)** Department Verification:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

(1 week)

  
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(2 weeks)

**~ 1 ~**



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**~** Page 2 **~**

  
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(3 weeks)