LSUHSC DEPT. OF ANESTHESIOLOGY

Documentation of Professional Services

DOCTOR'S NAME	MONTH OF SERVICE
ACTIVITIES: O.R./CLINICAL ANESTHESIA SERVICES	FACILITY NORTHSHORE REGIONAL MEDICAL CENTER /SURGERY SUITE

DATE	ARRIVAL TIME	DEPART TIME	ACTIVITY	INITIALS	DATE	ARRIVAL TIME	DEPART TIME	ACTIVITY	INITIALS

Total Hours Worked @ rate $_____ = $_____

Other: @ rate $_____ = $_____

Total **$_____**

Physician Certification

I hereby certify that I performed the services detailed in this invoice at this facility and that I received no other form of compensation from any other source for the same period of time.

_____

Physician Date

N/W= night/weekend coverage
SNW=shared night/weekend coverage; **note who coverage was shared with**
PNW= post night/weekend
AH= additional hours

LS*=late shift paid
LS#= late shift unpaid
H-TIME= holiday time
ADM= administrative day

IP=interventional pain
CC-UH= critical care conference & staffing