Medical Director Monthly Report

IMPORTANT NOTICE: *No compensation will be paid until the Monthly Report for that period is submitted.*
Report must be typed; handwritten reports will not be accepted.
Fill in Comment/Description box for each and every activity, and be specific
Monthly report is to be submitted to ComplianceOffice@UToledo.Edu by no later than the first Monday of the following month.

Department: ______________________________________

Name: ________________________________ **Month/Year:** ________________________

Activity Numbers	
1. Care Coordination with doctors, other staff, other departments 2. Educational (self, staff, others) 3. Miscellaneous*** 4. Meetings (patient, department, committee) 5. Time spent preparing or following-up from meetings etc.	6. Program evaluation activities, i.e., budgeting, survey, accreditation 7. Policy/procedure/development review 8. Equipment 9. Quality assurance/utilization review/record review ***Misc.: Please fill in in description and be specific

Date	Activity Number	Comments/Description	Time Spent

Date	Activity Number	Comments/Description	Time Spent
		Total Hours	0

I hereby certify that the above information is a true and accurate recording of the time spent on the duties required as Medical Director.

Print Name _____ Date _____ Signature _____

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Submitted Hours 0 hrs.

Hourly Rate $ _____ /hr.

Total $ 0.00

Contract Month/Year January 2010

Quarterly Review Months N/A

Ratio _____

Amount to Pay ____**%** $ 0.00

Held for Quarterly Review ____**%** $ 0.00

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Approved Amount: $ 0.00

Compliance Office

Name _____ Date _____ Signature _____

Chief Medical Officer

Name _____ Date _____ Signature _____