Weekly Attendance Worksheet

Claim Month:

Name	#	Date:	Date:	Date:	Date:	Date:
		B A L P D E In/Out In/Out	B A L P D E In/Out In/Out	B A L P D E In/Out In/Out	B A L P D E In/Out In/Out	B A L P D E In/Out In/Out
		☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐
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		☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐
		☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐
		☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐	☐ ☐ ☐ ☐ ☐ ☐ Attended: ☐
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I certify that to the best of my knowledge, this information is accurate in all respects. I understand this information is provided in connection with the receipt of federal funds and may be verified. I also understand that deliberate misrepresentation may result in state or federal prosecution.

Signature of Provider ____________________ Date __________ Provider Number __________