WEEKLY ATTENDANCE WORKSHEET

Provider Name					Claim Month / Year					
CHILD'S FIRST AND LAST NAME (please print clearly)	Monday		Tuesday		Wednesday		Thursday		Friday	
	Att	BALPD	Att	BALPD	Att	BALPD	Att	BALPD	Att	BALPD
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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 federa funds and may be verified. I also understand that deliberate misrepresentation may result in state or federal prosecution.										
Signature of Provider Da					Provider Number					

04/2024