

**SAN BERNARDINO CITY UNIFIED SCHOOL DISTRICT
CATEGORICAL PROGRAMS DEPARTMENT**

Supplemental Services Attendance Record Sheet

STUDENT NAME: _____ **FOR THE MONTH OF:** _____

SCHOOL: _____

Supplemental Service Provider: _____

Indicate number of hours on dates of attendance.

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Total hours of Attendance: _____ Hours Billed: _____ Hourly Rate: _____ Total Due: _____

Parent/Guardian/Student Signature: _____

I certify, under penalty of perjury, that the above information is true and correct:

Signature of supplemental service provider representative

Title

Date