The Arc Of East Central Iowa

IMMT Hours Log

Total Hours Month _____

****Please make sure to use Military time for all service hours ****

Consumer's Name:_____

Month:_____ Year:_____

Date	*Worker's Signature*	*Start Time*	*End Time*	*Total Hours*	*Authorized Signature*

680 2nd Street SE Suite 200 Cedar Rapids, IA 52401 Phone: 319-365-0487 Fax: 319-365-9938

I hereby give _____permission to administer the following prescribe medication(s) at the designated time(s):

Medication	Dosage	Time	Given For

_____ _____

Parent/Guardian Signature **Date**

Date/Time	Medication	Dosage	Initials