RIVERSIDE COUNTY OFFICE OF EDUCATION

Division of Early Education Services
Early Care and Education

Daily Sign-In/Sign-Out Record (DSSR)

Provider/Payee: _____ Provider ID No.: _____ Parent(s): _____

Address: _____ Month/Year of Service: _____ Child: _____

Provider Phone: _____ Child ID No.: _____

Date	Time In a.m. or p.m.	Time Out a.m. or p.m.	Time In a.m. or p.m.	Time Out a.m. or p.m.	Absence Reason	Date	Time In a.m. or p.m.	Time Out a.m. or p.m.	Time In a.m. or p.m.	Time Out a.m. or p.m.	Absence Reason
1						19					
2						20					
3						21					
4						22					
5						23					
6						24					
7						25					
8						26					
9						27					
10						28					
11						29					
12						30					
13						31					
14						Provider Invoicing/Family Fee Receipt MUST be Completed for Reimbursement Processing					
15						Calculation of Provider Requested Rate(s)/Other Fees:					+ $
16											+ $
17						State Family Fees Received, if applicable. Date Paid:					- $
18						Total Provider Invoice:					= $

PARENTS AND PROVIDERS: READ AND SIGN MONTHLY DECLARATION

I declare under penalty of perjury that the above information is true and that this child care was provided at the above location, for the sole purpose for which this child care was certified. I understand that I may be requested to repay any overpayment resulting from false or incorrect claim forms and that I may be prosecuted for fraud, if so determined.

Full Signature of Provider: _____ Date: _____ Full Signature of Parent: _____ Date: _____