



Knox County Mental Health Court (KCMHC) Community Service Form

Community Service Agency: _____

Contact Name: _____ Title: _____

Contact Telephone: _____

Name of Individual Performing Community Service: _____

DOB: _____

Total Hours Assigned: _____ Date to be completed by: _____

Date	Time In	Time Out	Total Hours	Subtotal Hours	Supervisor Initials	Participant's Initials

I certify that the above record is a true representation of the number of hours worked for the above period.

Approved by:

Signature of Community Service Partner Representative

Date

Signature of Participant Performing Community Service

Date