MEDICAID CLERICAL WORK ORDER

AC#_____

_____	_____	_____
AUDITEE	PERSON TO RECEIVE REPORT	ADDRESS

PENCIL DRAFT TO TYPING: _____
AUDIT MANAGER

TYPED DRAFT: _____ _____ _____ _____
QTY. CONTROL AUDIT MANAGER AUDIT DIRECTOR DEPUTY

FINAL REPORT: _____ _____ _____ _____
QTY. CONTROL AUDIT MANAGER AUDIT DIRECTOR DEPUTY

DATE	TIME*	SIGNATURE	DESCRIPTION	PROOFED BY
			TYPE DRAFT	
			CORRECTIONS	
			CORRECTIONS	
			CORRECTIONS	
			CORRECTIONS	
			TYPE FINAL	
			CORRECTIONS	
			CORRECTIONS	
			CORRECTIONS	

* ROUNDED TO NEAREST 0.1 HOURS

_____ _____
DATE DRAFT MAILED DATE FINAL REPORT RELEASED

STAFF ASSIGNED:

MANAGER _____

SUPERVISOR _____

IN-CHARGE _____

ASSOCIATES _____

BUDGET:

BUDGET HOURS _____

ACTUAL HOURS _____

UNDER/<OVER> _____