



"a company of nursing excellence"

TIMESHEET

EMPLOYEE NAME:						PERIOD COVERING: / / THROUGH / /					
PHONE #:						FACILITY NAME:					
MAILING ADDRESS:						FACILITY CONTACT:					
						FACILITY ADDRESS:					

Please fax approved timesheet to 859.523.6802 by NOON EST on MONDAY following completion of pay cycle.

Day of Week	Month/Day	Unit	Shift Start	Meal Break	Shift End	Regular Hours	Overtime Hours	Double-time Hours	On-Call Hours	Call-Back Hours	Charge Hours	Holiday Hours
SUN												
MON												
TUES												
WED												
THUR												
FRI												
SAT												

TOTAL HOURS	REGULAR	OT	DT	ON-CALL	CALL-BACK	CHARGE	HOLIDAY

I certify that the hours on this timesheet are accurate and reflect actual hours worked by me during the week designated and were verified by authorized personnel.

EMPLOYEE SIGNATURE

I certify that the above named employee has performed satisfactory services for the dates and times indicated and authorize billing for such services.

CLIENT AUTHORIZED SIGNATURE

original - fax to office/retain for personnel records yellow - client