



Staff Timesheet

REPORT ALL TIME TO NEAREST ¼ HOUR

Week Ending _____

#1 in quality service and quality care

FACILITY NAME
STREET ADDRESS
CITY
STATE ZIP CODE

DAY	DATE	CIRCLE SHIFT WORKED	UNIT FLOOR	TIME IN	LESS MEAL BREAK	TIME OUT	HOURS TO BE BILLED & PAID	CLIENT MUST SIGN EACH DAY
MON		1 2 3						
TUES		1 2 3						
WED		1 2 3						
THURS		1 2 3						
FRI		1 2 3						
SAT		1 2 3						
SUN		1 2 3						

IMPORTANT FOR CLIENT
 It is hereby certified by the client company that the above hours are reported correct and that work was performed by the named person in a satisfactory manner.

Employee Name (Print) _____

Social Security # _____

RN LPN STNA Other

Authorized Signature Date

X _____

Employee Signature X _____

ORIGINAL: FACILITY

COPY: Med1CARE, LLC

COPY: EMPLOYEE

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