Staff Timesheet

MED1CARE, LLC.

#1 In quality service and quality care

REPORT ALL TIME TO NEAREST ¼ HOUR

Week Ending _____

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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