healthcare staffing
bluegrass

"a company of clinical excellence"

TIMESHEET

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

Please fax approved timesheet to 859.201.1124 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 personal records yellow - client

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