HSA Where Compassion, Innovation & Trust Meets You!

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Email:
timesheet@healthcarestaffingofamerica.net

Web: www.healthcarestaffingofamerica.net

Date: _____

Facility: _____

EMPLOYEE NAME:	TITLE:
EMPLOYEE NUMBER:	STATUS: AGENCY
DEPARTMENT: NURSING	FACILITY TIME CLOCK: YES _____ NO _____

DATE	START TIME	MEAL BREAK	END TIME	TOTAL HOURS
Date: Monday				
Date: Tuesday				
Date: Wednesday				
Date: Thursday				
Date: Friday				
Date: Saturday				
Date: Sunday				
WEEKLY TOTALS				

I RECOGNIZE THAT THE RIGHTS OF NURSES THAT AID, LLC AS THE EMPLOYER AND AGREE NOT TO EMPLOY DIRECTLY IN ANY CAPACITY THE PERSON NAMED HERE WITHOUT FIRST PROVIDING NURSES THAT AID, LLC AT LEAST 90 DAYS WRITTEN NOTICE FOLLOWING THE TERMINATION OF THIS ASSIGNMENT. I CERTIFY THAT THE HOURS SHOWN ABOVE ARE CORRECT AND THAT THE EMPLOYEE PERFORMED SATISFACTORILY. _____ **AUTHORIZED SIGNATURE**	DATE:
I CERTIFY THAT THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS OF WORK AND THAT THEY WERE PROPERLY VERIFIED BY THE CLIENT OR AUTHORIZED REPRESENTATIVE. I ALSO CERTIFY THAT I WAS NOT INJURED ON THE ABOVE SHIFT. I CERTIFY THAT I HAVE USED THE FACILITY TIME CLOCK FOR TIME KEEPING PURPOSES. _____ **EMPLOYEE SIGNATURE**	DATE: