Employee Name: _____ Employee Signature: _____ Date: _____

Facility Name: _____ Facility City/State: _____

I certify that the hours were worked by me on the dates designated hours are true and correct; verified by a representative of the facility.

By signing above, customer acknowledges that all hours are true and Correct; and has read and agreed to all terms in the client agreement.

	Date	Time In	Lunch	Time Out	Total Hours	Specialty CNA or STNA	Covid Yes or No	Call-Off Reason (2 hour show up Pay)	Signatures
Sun		:	30	:					
Mon		:	30	:					
Tue		:	30	:					
Wed		:	30	:					
Thu		:	30	:					
Fri		:	30	:					
Sat		:	30	:					
				TOTAL HOURS FOR WEEK					

Payroll Information - For Office Use Only

Travel	$		Misc Reimbursement	$	
Medical	$		Other	$	
Licensure	$		Other	$	

Please send completed *SIGNED* timecards to payroll@AnalyticsMedStaff.com by Sunday Night

PLEASE USE A DIFFERENT TIMECARD FOR EACH FACILITY WORKED

Analytics Medical Staffing Solutions, Inc. • 8080 Beckett Center Dr. Suite 316 West Chester, OH 45069 •
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