Wise Medical Staffing

WEEKLY TIMESHEET

FACILITY NAME: _____

EMPLOYEE NAME: _____

LAST 4 OF SS#: _____ CIRCLE ONE: RN LPN CNA STNA SRNA GNA

WEEK BEGINNING _____ WEEK ENDING _____

UNIT/FLOOR: _____

DAY OF WEEK	TIME IN	MEAL/LUNCH	TIME OUT
SUNDAY	AM/PM	*30 MINUTES	AM/PM
MONDAY	AM/PM	*30 MINUTES	AM/PM
TUESDAY	AM/PM	*30 MINUTES	AM/PM
WEDNESDAY	AM/PM	*30 MINUTES	AM/PM
THURSDAY	AM/PM	*30 MINUTES	AM/PM
FRIDAY	AM/PM	*30 MINUTES	AM/PM
SATURDAY	AM/PM	*30 MINUTES	AM/PM

*FACILITY VERIFICATION/MANAGER APPROVAL FOR NO MEAL: _____ (INITIALS)

*IF NO MEAL, VERIFIABLE REASON: _____

ASSIGNED EMPLOYEES ARE EMPLOYEES OF WISE MEDICAL STAFFING. A RECRUITMENT FEE OF 20% OF ANNUAL SALARY WILL BE DUE IF YOU CHOOSE PERMANENT RETAINMENT OF EMPLOYEE. OVERTIME IS WORKED ON A VOLUNTARY BASIS ONLY AND IS PAID TIME AND ONE-HALF REGULAR RATE AND IS BILLED AS SUCH (OR YOUR CONTRACTUAL RATE IF DIFFERENT).

AUTHORIZED CLIENT SIGNATURE: _____

PRINTED NAME (PLEASE TYPE LEGIBLY): _____

DATE: _____

I CERTIFY THAT THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS WORKED AND THAT THEY WERE PROPERLY VERIFIED BY THE CLIENT OR AN AUTHORIZED REPRESENTATIVE. I CERTIFY THAT I WAS NOT INJURED ON THE ABOVE SHIFT.

EMPLOYEE SIGNATURE: _____

USE BLACK OR BLUE INK ONLY