

PREMIER HEALTHCARE STAFFING

OFFICE USE ONLY - DO NOT WRITE IN THIS AREA

EMPLOYEE'S NAME

CLIENT'S NAME

HOSPITAL UNIT

PAY PERIOD FROM:

TO:

NOTE: UNDOCUMENTED LUNCH BREAKS WILL BE DEDUCTED @1/2 HR PER DAY UNLESS NOTED (NO LUNCH)

DAY	DATE	SHIFT	DEPT/ UNIT	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	TOTAL HOURS	IN-CHARGE HOURS	ON-CALL HOURS	CALL BACK HOURS	HOME HEALTH		COMMENTS	
												# OF VISITS	MILEAGE		
SUNDAY															
MONDAY															
TUESDAY															
WEDNESDAY															
THURSDAY															
FRIDAY															
SATURDAY															
SUNDAY															
MONDAY															
TUESDAY															
WEDNESDAY															
THURSDAY															
FRIDAY															
SATURDAY															
TOTAL HOURS															

EMPLOYEE SIGNATURE _____

CLIENT APPROVAL _____

DATE _____

DATE _____

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