



# WEEKLY TIME CARD

FAX: 973-718-4350 or 800-292-4086      PHONE: 1-(866)-241-3396

HOSPITAL NAME: \_\_\_\_\_  
(Please print)

WEEK ENDING DATE: \_\_\_\_\_

EMPLOYEE NAME: \_\_\_\_\_  
(Please print)

EMPLOYEE SIGNATURE: \_\_\_\_\_  
Your signature here verifies that all hours are correct

Daily "Time In" and "Time Out" will assume a 1/2 hour meal deduction

PAYMENT:  Weekly Check     Direct Dep     Cash Card

Day	Date	Unit	Time in	Time Out	Total Break	Total Hrs Worked	Authorized Signature For No Break And/Or Extra Hours	Hospital Shift Signature
SUNDAY								
MONDAY								
TUESDAY								
WEDNESDAY								
THURSDAY								
FRIDAY								
SATURDAY								

Total Weekly Hours:

**“No injuries or accidents occurred on this Shift” to be initialed by the employee**

*If any injury did occur notify the nursing supervisor and Nurses 24/7 Immediately before leaving your shift, failure to do so may result in delay or denial of workman's compensation benefits*

**\*\*\*IMPORTANT: (IN ORDER TO BOTH PAY AND BILL ACCURATELY)\*\*\***

- ALL 8 TO 12 HOUR SHIFTS REQUIRE A BREAK TO BE TAKEN. NO NURSE WILL BE PAID FOR BREAK WITHOUT AUTHORIZATION.
- ALL TIMECARDS MUST BE FILLED OUT COMPLETELY AND ACCURATELY.
- NURSE MUST CONFIRM TIMECARD RECEIPT WITH AGENCY (Do not solely rely on electronic fax confirmations)
- DOUBLE SHIFTS MUST BE FILLED OUT ON SEPARATE TIMECARDS
- IF YOU ARE WORKING AT A FACILITY THAT DOES NOT SIGN TIMECARDS, THE TIME YOU SUBMIT TO US MUST MATCH THE SIGN IN SHEET AT THE FACILITY OR DEDUCTIONS WILL BE MADE.

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