WEEKLY TIMESHEET

Hospital Name ______________________________ City / State ______________________________

Employee Name ______________________________ Unit ______________ SSN# ______________

Date From ____________ To ______________ Assigned Shift ______________________________

	Saturday	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday
Date							
Time-In							
Time-Out							
Meal							
Totals							
Regular							
OT							
DT/Holiday							
On-Call							
Call-back							
Charge							
Unit							
Notes (if any):							
Employee Signature and Date				Authorized Hospital Staff Signature, Print name and Date			

Completed Timesheets must be sent by fax before 03.00 PM EST Monday to ensure prompt payment in the same week.

EMAIL TO PAYROLL@CLOVERSTAFFING.COM (OR) FAX TIMESHEET TO: (877) 579-8823