CLOVER HEALTH SERVICES

WEEKLY TIMESHEET

Hospital Name _____ City / State _____

Employee Name _____ Unit _____ SSN# _____

Date From _____ To _____ Assigned Shift _____

	Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday
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