



# WEEKLY TIMESHEET

Hospital Name \_\_\_\_\_ City / State \_\_\_\_\_  
 Employee Name \_\_\_\_\_ Unit \_\_\_\_\_ SSN# \_\_\_\_\_  
 Date From \_\_\_\_\_ To \_\_\_\_\_ Assigned Shift \_\_\_\_\_

	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Monday
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**