



# WEEKLY TIMESHEET

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

	Wednesday	Thursday	Friday	Saturday	Sunday	Monday	Tuesday
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
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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**