Employee Name: _____

RN _____ LPN _____ RT _____ CNA_____ MA_____

Facility Name/Dept: _____

DAY	DATE	LUNCH BREAK	START TIME	STOP TIME	HOURS WORKED	AUTHORIZED CLIENT INITIALS
Sunday		Y N				
Monday		Y N				
Tuesday		Y N				
Wednesday		Y N				
Thursday		Y N				
Friday		Y N				
Saturday		Y N				
Time to the Nearest Quarter (1/4) hour			**TOTAL HOURS:**			

TIMESHEETS DUE AFTER EACH SHIFT WORKED

FAX TO: 412.440.5261

Employee Acknowledgement: I certify that the above hours are a true representation of my time worked and that I have obtained an authorized signature from a facility/client representative. I recognize the rights of McNeely Staffing as the employer and agree not to be employed by the facility individually or through an agent for a period of (90) days following the termination of this agreement without approval of McNeely Staffing. I certify that no injury was incurred by me during this agreement.

Employee Signature: _____

Client Acknowledgement: I am an authorized agent of the facility/client listed above and certify that the hours listed are correct and that the employee performed their duties in a satisfactory and professionally competent manner. I recognize the rights of McNeely Staffing as the employer and agree not to employ or encourage the employment of the above McNeely Staffing employee for a period of (90) days followng the completion of any assignment. I certify that the above hours are correct.

Client Signature: _____