



HOSPITAL INFORMATION		EMPLOYEE		
Hospital Name (including city and state)		Last Name	First Name	Week-Ending Date
				<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

USE 24 HOUR (MILITARY) TIME. *Do Not Include On Call - Not Worked or On Call - Worked (Called In) in the Total Hours. See CALL TIME SECTION Below.

DAY	Dates		Time In		Lunch		Time Out		Total Hours Worked*		Cost Center or Unit	Do Not Write in This Space
	Mnth	Day	Hour	Minutes	Hour	Minutes	Hour	Minutes	Hour	Minutes		
Sun				:		:		:		:		
Mon				:		:		:		:		
Tue				:		:		:		:		
Wed				:		:		:		:		
Thur				:		:		:		:		
Fri				:		:		:		:		
Sat				:		:		:		:		
TOTALS					

ON CALL HOURS WORKED											On Call not Worked		Do Not Write In This Space
DAY	Dates		Time In		Lunch		Time Out		Total Call Hours*		Total		
	Mnth	Day	Hour	Minutes	Hour	Minutes	Hour	Minutes	Hour	Minutes	Hour	Minutes	
Sun				:		:		:		:		:	
Mon				:		:		:		:		:	
Tue				:		:		:		:		:	
Wed				:		:		:		:		:	
Thur				:		:		:		:		:	
Fri				:		:		:		:		:	
Sat				:		:		:		:		:	
TOTALS				

HOSPITAL AUTHORIZATION The total number of hours worked is correct Hospital Authorized Signature _____ Date _____	ALTERNATE MAILING INFORMATION <i>If no address is provided, check will be sent to the address on file.</i> Send Check or Stub To: <input type="checkbox"/> Fed Ex (15.00 fee)	EMPLOYEE TIMESHEET CERTIFICATION Employee Signature** _____ Date _____ **My signature above acknowledges that the time I have entered above is correct and accurate, and I have not been coerced or encouraged in any manner to enter inaccurate hours. During this workweek, I have taken all the unpaid breaks to which I was entitled and have taken all unpaid meal periods or signed waivers for all on duty meal periods.
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