

Name: _____



Critical Nursing Solutions Inc.

TIMECARD

ONE FACILITY PER TIMECARD

Week Ending: ____/____/____

Client: _____

Unit/Floor: _____

Date:	Regular Hours:				Standby/On-Call Hours:			Hours Worked On-Call:			Supervisor Approval:
	Begin:	End:	Break:	Total:	Begin:	End:	Total:	Begin:	End:	Total:	
Sun: ____/____			.50								X
Mon: ____/____			.50								X
Tue: ____/____			.50								X
Wed: ____/____			.50								X
Ths: ____/____			.50								X
Fri: ____/____			.50								X
Sat: ____/____			.50								X
Fax to: 480-452-0308 or 888-584-8081				Weekly Total:		Weekly Total:		Weekly Total:			

***PLEASE CALL TO VERIFY YOUR TIMECARD HAS BEEN RECEIVED

Weekly Payroll _____ CNSIPS _____
(Instant Pay)

I hereby certify that the hours shown above represent my total hours worked and the client approval was signed by my supervisor or an authorized representative of the client.

UNSIGNED TIMECARDS WILL RESULT IN DELAY OF COMPENSATION

Employee Signature (required)

ALL TIMECARDS MUST BE SIGNED BY FLOOR/UNIT SUPERVISOR

Date ____/____/____

ANY HOURS OVER SCHEDULED SHIFT MUST BE HAVE FACILITY EXEMPTION FORM ATTACHED