



(216) 252-4577 • Fax (216) 712-7266

EMPLOYEE NAME	FACILITY NAME	DEPARTMENT OR LOCATION
---------------	---------------	------------------------

DISCIPLINE	WEEK ENDING DATE (SATURDAY)	
DATE	STARTING TIME	FINISH TIME
		LESS LUNCH
		DAILY TOTAL
		UNIT
		CLIENT SIGNATURE
		EACH SEPARATE DAY

SUN				30-MIN			
MON				30-MIN			
TUE				30-MIN			
WED				30-MIN			
THU				30-MIN			
FRI				30-MIN			
SAT				30-MIN			

Timeslips must be received by 9:00 AM on Monday following the week worked.

I certify the hours shown are the total hours worked by me during the week for the company named above and these hours have been verified by my supervisor or another authorized representative of the company. I certify there were no incidents, accidents or injuries during the hours worked by me.

X \_\_\_\_\_  
 (Employee Signature) (Date)

Times reflected on timeslip must match submitted times worked at each facility



	TOTAL WEEKLY HOURS <i>(Do not include lunch time)</i>	STRAIGHT TIME				
		OVERTIME				

Failure to obtain all necessary signatures or complete timesheet may result in non-payment or delay of payment for hours worked.