




(216) 252-4577 • Fax (216) 712-7266

EMPLOYEE NAME			FACILITY NAME				DEPARTMENT OR LOCATION		
DISCIPLINE		WEEK ENDING DATE (SATURDAY)						CLIENT SIGNATURE EACH SEPARATE DAY	
DATE	STARTING TIME	FINISH TIME	LESS LUNCH	DAILY TOTAL	UNIT				
SUN			30-MIN						
MON			30-MIN						
TUE			30-MIN						
WED			30-MIN						
THU			30-MIN						
FRI			30-MIN						
SAT			30-MIN						
 Veteran Owned			TOTAL WEEKLY HOURS <i>(Do not include lunch time)</i>	STRAIGHT TIME					
				OVERTIME					

Timeslip must be received "daily" by emailing it to timeslip@anchormedicalstaffing.com

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

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



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