Freedom Healthcare Staffing

Company Name: Freedom Healthcare Staffing		
Employee Name:		
Date:	Unit:	Job Title:

Start Time/Date:	___ ___ : ___ ___
Less Meal Break: (Meal break is required unless authorized)	0 0 : 3 0
End Time/Date:	___ ___ : ___ ___

Total Hours Worked: ___ ___ : ___ ___

I certify that the hours shown above are correct. I also certify that I was not injured during the performance of my shift:

_____

Facility Use Only:	
Missed Meal Break Approval	Overtime Hours Approval
_____ *Authorized Signature*	_____ *Authorized Signature*
Missed Meal Break and Overtime MUST be authorized by a Nurse Supervisor, Nurse Manager, Staffing Office, or other authorized Facility representative.	
Total Hours Facility Approval: _____	

PLEASE MAKE COPY OF TIMESHEET TO REMIT TO FACILITY AT THE END OF EACH SHIFT. THANK YOU.