HELPING HANDS NURSING LLC.

(785) 893-0954

EMPLOYEE NAME:_____ WEEK:_____

TIMESHEETS DUE SUNDAY BY 8AM One timesheet per week EMAIL to: **time-keep@helpinghandsnsg.com**

DAY	DATE	TITLE/ Position Worked (include both)	FACILITY	TIME IN AM/PM	30 MIN BREAK Nurse Initial if No	TIME OUT AM/PM	TOTAL HOURS	TOTAL MILEAGE Roundtrip	COVID Nurse initial	NURSE SIGNATURE
SUN										
MON										
TUE										
WED										
THU										
FRI										
SAT										

I Certify that the hours shown above represent my total hours worked and are verified by the facility or authorized representative.

EMPLOYEE SIGNATURE:_____**DATE:**_____

IMPORTANT FOR THE CLIENT: By execution of this form, client certifies 1.) The above hours are correct and the work was done in a satisfactory manner. 2.) Agrees to pay for the services provided by the above mentioned employee of Helping Hands Nursing.