DAILY TIME CARD

FAX: **800-292-4086 or 973-718-4350** PHONE: **1-(866)-241-3396**

Facility/Client_____ Floor/Unit_____ Specialty_____

Employee _____ Social Security # _____ O OT O PT O PTA
O SLP O COTA O Other

Date	Day OF Week	Time IN	Time OUT	Total Break	Total Hour Minus Break (If no break is taken timecard must be authorized below)
	Mon Tue Wed Thu Fri Sat Sun	AM PM	AM PM		

I certify the hours shown above represent my total hours worked and that they were properly verified by the client or an authorized representative.

Employee Signature:_____ Method of Payment: O Mail Check (weekly) O Direct Deposit (must be in by 9am For 24 hr deposit) O Cash Card

I hereby certify that I am an Authorized Representative of this facility and the above information is correct for billing purposes

Authorized Representative (Signature Required): _____

Extra Hours Authorized (Signature Required): _____

No Lunch Authorized (Signature Required): _____

_____ **"No injuries or accidents occurred on this Shift" to be initialed by the employee**

If any injury did occur notify the allied health supervisor and Nurses 24/7 Immediately before leaving your shift, failure to due so may result in delay or denial of workman's compensation benefits

*****IMPORTANT: (IN ORDER TO BOTH PAY AND BILL ACCURATELY)*****

- ALL 8 TO 12 HOUR SHIFTS REQUIRE A BREAK TO BE TAKEN. NO NURSE WILL BE PAID FOR BREAK WITHOUT AUTHORIZATION.
- ALL TIMECARDS MUST BE FILLED OUT COMPLETELY AND ACCURATELY.
- NURSE MUST CONFIRM TIMECARD RECEIPT WITH AGENCY (Do not solely rely on electronic fax confirmations)
- DOUBLE SHIFTS MUST BE FILLED OUT ON SEPARATE TIMECARDS
- IF YOU ARE WORKING AT A FACLITY THAT DOES NOT SIGN TIMECARDS, THE TIME YOU SUBMIT TO US MUST MATCH THE SIGN IN SHEET AT THE FACILITY OR DEDUCTIONS WILL BE MADE.

*****ASK US ABOUT FREE ONLINE ACCOUNT ACCESS*****