CLINICAL STAFF SUPPORT, INC NURSING GROUP, INC

EMPLOYEE WEEKLY TIMESHEET

Ph: 800-331-1531 Fax: 800-331-1531

EMPLOYEE NAME:____ TITLE: ____________________________

FACILITY NAME:____ CITY:_____________________________

DATE	TIME IN	TIME OUT	UNIT/FLOOR	LUNCH	TOTAL HOURS	EMPLOYEE SIGNATURE	FACILITY REPRESENTATIVE SIGNATURE
Sunday / /							
Monday / /							
Tuesday / /							
Wednesday / /							
Thursday / /							
Friday / /							
Saturday / /							
				Total Hours			

By signing this timesheet, I the facility representative agree to the terms of net upon receipt and to pay interest on unpaid balances, accounts, invoices which are over 30 days old at a rate of 1.5% per month (APR18%) to the maximum legal interest rate allowed by law, which ever is lower, together with reasonable attorneys fees. I certify that the hours shown above are correct and the employee performed satisfactorily