Medical Staffing Partners

Invoice #: _____

Client #: _____

Weekly Time Record

Employee: _____ **Hospital Name:** _____

Employee phone: _____ **Manager:** _____

Address to send check: _____ **Manager phone:** _____

_____ **Manager E-mail:** _____

Week ending: _____ **PP#:** _____

Day	In	Lunch	Out	Charge	Regular Hrs Total	O/T Hrs Total	On Call Not Worked In	On Call Not Worked Out	On Call Not Worked Total	On Call Worked In	On Call Worked Out	Charge	Total
Sunday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Monday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Tuesday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Wednesday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Thursday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Friday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
Saturday	AM	OUT	AM	Y	Total	Total	AM	AM	Total	AM	AM	Y	Total
	PM	IN	PM	N			PM	PM		PM	PM	N	
					Total	Total			Total				Total

**** For any missed hours this week, document the reason on this timesheet ****

I did not receive my guranteed hours due to:

- ☐ Hospital cancelled/reduced shift(s)
- ☐ Hospital did not schedule me
- ☐ I took time off
- ☐ Other_____

I affirm that the above information is accurate and correct. I understand that false or misleading information will be grounds for immediate termination of my employment contract.

_____ _____

Employee Signature Date Manager Signature Date

***** Please complete and fax back to 1-800-544-2602 or 651-407-8977 by Monday 12:00pm CST ****

**** Telephone Number: 651-407-0300 or 800-896-4164 ****

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