Medflex Staffing Services, LLC

316.519.5583

WEEK: ____________________ EMPLOYEE: ____________________
(PRINT NAME)

MAKE A COPY AT THE END OF EACH SHIFT FOR FACILITY

DAY	FACILITY	DATE	TITLE	TIME IN AM or PM	30 MIN BREAK Y or N	TIME OUT AM or PM	TOTAL HOURS WORKED	TOTAL ROUNDTRIP MILEAGE	SUPERVISOR SIGNATURE
SUN									
MON									
TUES									
WED									
THURS									
FRI									
SAT									

I CERTIFY THAT THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS WORKED AND ARE VERIFIED BY THE FACILITY OR AUTHORIZED REPRESENTATIVE.

USE ONE TIMESHEET PER WEEK. EMPLOYEE SIGNATURE: ____________________