P.O.BOX 1030
REDWOOD CITY,CA 94064
TEL:(650)995-7224
FAX(650)995-7846
www.staffhospital.com

TIME SHEET

EMPLOYEE NAME: (CRT) SSN:	PAYCHECK DELIVERY INSTRUCTION
FACILITY NAME & DEPT:	☐ Direct Deposit
FACILITY ADDRESS:	☐ Regular Mail
SUPERVISOR NAME:	☐ FedEX Overnight
DEPT PHONE:	☐ Other: (Fee paid by employee)

TIME SHEETS ARE DUE NO LATER THAN 4:00 PM MONDAY. THE FOLLOWING WEEK SIGNED & CORRECT

DAY	DATE	TIME IN	TIME OUT	LESS LUNCH	TOTAL HOURS	TOTAL OVERTIME	OFFICE USE ONLY
SUN							
MON							
TUES							
WED							
THURS							
FRI							
SAT							
				TOTALS	REG	OT	

ON CALL HOURS				WORKED CALLBACK HOURS ONLY			
DATE	START TIME	END TIME	TOTAL HOURS	DATE	TIME IN	TIME OUT	WORK HOURS
TOTAL ON CALL HOURS:				TOTAL CALLBACK HOURS:			

COMMENTS AND EXPLANATION OF MISSED HOURS:

I certify the hours shown above were worked by me during the week designated and was verified by authorized personnel. I certify no injury or accident was sustained by myself while working on this assignment unless so noted in the above comment. I agree to contact RTP after the completion of any assignment. If I fail to do so RTP may assume that I am not available to work.

I hereby certify the above named employee has performed satisfactory service for the days and times indicated and authorize billing for such service. In the even the above named individual is hired by this facility or subsidiary within the time period specified in the contract, I agree to pay to RTP a fee per contract agreement as liquidated damage.

EMPLOYEE SIGNATURE DATE CLIENT SIGNATURE DATE