



**WEEKLY TIME SHEET**

CLINICAL STAFF SUPPORT, Inc  
 Fax 1.866.289.3893 Fax 218.0904 Ph 512-799-0935  
 www.nursinggroup.com

**EMPLOYEE NAME:** \_\_\_\_\_ **TITLE:** RN \_\_\_\_\_ LVN \_\_\_\_\_ CNA \_\_\_\_\_

**FACILITY NAME:** \_\_\_\_\_ **CITY:** \_\_\_\_\_

Day And Date	Time In	Time Out	Unit/Floor	Total Hours	Employee Signature	Facility Representative Signature	Faxed
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
<b>TOTAL HOURS</b>							

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