



LOVE- NURSE & ALLIED STAFFING
DAILY TIME SHEET

Email: Allclin@lovenursingstaff.com Fax:443.227.4476

Has direct deposit information changed? **Y / N** (circle one)

If yes: Routing#/Acct #: (*not for facility use)

_____ / _____

EMPLOYEE SIGNATURE: _____

EMPLOYEE NAME: _____

FACILITY: _____

DEPARTMENT: _____

TIME IN: _____ TIME OUT: _____

LUNCH BREAK (LENGTH): _____

IF NO BREAK SUPERVISOR MUST INITIAL HERE: _____

WAS PRACTITIONERS' PERFORMANCE SATISFACTORY?
YES ___ NO ___

COMMENT(S):

SHIFT SUPERVISOR SIGNATURE:

DATE: _____

*MAKE COPY FOR YOUR RECORD



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_____ / _____

EMPLOYEE SIGNATURE: _____

EMPLOYEE NAME: _____

FACILITY: _____

DEPARTMENT: _____

TIME IN: _____ TIME OUT: _____

LUNCH BREAK (LENGTH): _____

IF NO BREAK SUPERVISOR MUST INITIAL HERE: _____

WAS PRACTITIONERS' PERFORMANCE SATISFACTORY?
YES ___ NO ___

COMMENT(S):

SHIFT SUPERVISOR SIGNATURE:

DATE: _____

*MAKE COPY FOR YOUR RECORD



LOVE- NURSE AND ALLIED
STAFFING- WEEKLY TIME SHEET

Email: Allclin@lovenursingstaff.com

Fax: 443.227.4476

Has direct deposit information changed? **Y / N**
(circle one) if yes:

Routing/Acct #: (not for facility use)

_____ / _____

Employee Signature: _____

EMPLOYEE NAME: _____

FACILITY: _____

DEPARTMENT: _____



DATE:	TIME IN	TIME OUT	LUNCH (LENGTH)	IF NO LUNCH SUPERVISOR MUST INITIAL (EACH DATE)
Sun				
M				
Tu				
We				
Thu				
Fri				
Sat				

WAS PERFORMANCE SATISFACTORY? Yes___ NO___

COMMENT(S):

SUPERVISOR SIGNATURE _____ DATE: _____

*MAKE A COPY FOR YOUR RECORD