skilled staffing solutions

Employee Name:_____

Facility: _____
HOSPICE OF CINCINNATI

Please Circle:
Title: **RN** **LPN** **STNA**

Day	Date	Unit	Time In	NO lunch must be initialed by the supervisor Lunch Out	Lunch In	Time Out	Total Hours	**Supervisors Signature** **(By signing, I certify that I have reviewed and agree that the total hours reported are correct)**
Sunday								
Monday								
Tuesday								
Wednesday								
Thursday								
Friday								
Saturday								

By Signing, I certify hours reported are accurate and reflect actual hours worked.

_____
Employee Signature Date

FAX Timesheets to: **513-745-9024** or **EMAIL** (mickig@sssolutions4u.com) by **Monday at 10 am** (to ensure your pay will be processed in a timely manner). Submitting Timesheets any later will delay your pay check.
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