AMN Healthcare Timecard - KFH/Hospital

Name: ______________________ Fax #: 888-667-7101

Per Diem?: ☐ Yes ☐ No Facility: ______________________ Code: __________ Pay Cycle: WEEKLY

Date	Time In (24h)	Meal Period (mins)	Time Out (24h)	Cost Center/ Department	Shift not worked at request of: F-Facility HP-Healthcare Prof'l	Kaiser Use Only: Regular	OT1/HOL	OT2	Missed Meal/Break Authorization (Initials)
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					WEEKLY TOTAL				

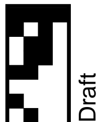
Please do not sign in and out at the same time.

Thank you for printing neatly and within the boxes.

Agency: *TheraEx Staffing*

Primary GL Code: ______________________

Comments:



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I affirm that the time recorded above is accurate and all required approvals have been obtained.

Dated: __________ Healthcare Professional's Signature: ______________________

The undersigned certifies that he or she is an authorized representative of the client company and that the above record of time worked by the named employee is correct. Payroll cannot process timecards without an authorized signature.

Print Name: ______________ Title: ______________ Contact #: ______________

Facility Authorization: ______________________ Dated: __________

Documentation of all hours worked (timecard) must be received by 5:00 pm PT Monday after the end of the pay period.