### AMN Healthcare Timecard - KFH/Hospital

**Name:**

**Facility:**

**Date**

**Per Diem?:** [ ] Yes [ ] No

**Time Card:**

**Meal Period (mins):**

**Time In (24h):**

**Time Out (24h):**

**Cost Center/Department:**

**Shift not worked at request of:**

**F-Facility HP-Healthcare Prof:**

**Regular**

**OT1/HOL**

**OT2**

**Kaiser Use Only**

**WEEKLY**

**TOTAL**

**Per Diem?:**

**Primary GL Code:**

**Agency:**

**TheraEx Staffing**

**Comments:**

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.

Thank you for printing neatly and within the boxes.