

# AMN Healthcare Timecard - KFH/Hospital

Name: \_\_\_\_\_

Fax #: 888-667-7101

**Per Diem?:**  Yes  No

Facility: \_\_\_\_\_

Code: \_\_\_\_\_

Pay Cycle: WEEKLY

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

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			Missed Meal/Break Authorization (Initials)
						Regular	OT1/HOL	OT2	
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<b>WEEKLY TOTAL</b>						<input type="text"/>	<input type="text"/>	<input type="text"/>	

Thank you for printing neatly and within the boxes.

Agency: **TheraEx Staffing**

Primary GL Code: \_\_\_\_\_

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

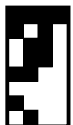
Dated: \_\_\_\_\_ Healthcare Professional's Signature: \_\_\_\_\_

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: \_\_\_\_\_

**Comments:**



Draft

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