EMPLOYEE: _____

FACILITY: _____

Summit Medical Staffing

Day	Date	Unit	Time In	Lunch *SEE NOTE	Time Off	Total Hours	Total Charge Hours	On Call on/off	Total	Call Back in/out	Total	Comments
Example:	**1/10/03**	145-ER	07:00	30" or .5	15:30	8.0		15:30-19:00	3.5	19:00-23:30	4.5	----------
Sun												
Mon												
Tues												
Wed												
Thurs												
Fri												
Sat												
Totals												

***If no break is taken, please indicate with N/L. If left blank, 30 minutes will be deducted from total hours for the day.

Time cards must be faxed in by Monday 12 pm (Central Standard Time). Anything after this time will be considered late and will not be paid until the following week. Missing information may result in a delay of payroll processing.

Please have supervisor/manager sign prior to faxing. Unsigned timecards will not be processed.

Please fax to Summit Medical at 855-728-5397

_____

Employees Signature

I certify by my signature that I have worked the hours shown on this time sheet. Misrepresentation may result in termination.

_____

Supervisors Signature

I verify the above named employee has worked the hours shown on this time sheet and agree to pay Summit Medical Staffing within the terms set forth in client agreement.