



EMPLOYEE TIME SHEET

EMPLOYEE NAME: _____
 SSN # (LAST 4 DIGITS ONLY): _____

Payroll Department
 76855 Hwy 207
 Echo, OR 97826

FAX (208) 378-1358

FACILITY NAME: _____
 CITY/STATE: _____

If you would like to confirm your timecard was received, please call or text 541-314-5009.

*Fill out one time card for each facility worked each week

Day	Date	Unit	Time In	Time Out	Lunch	Regular Hours	OT	Holiday	Orientation	On-Call	Call-Back	Charge Nurse	Travel	DAILY TOTAL	Hospital Rep. Initials
SUN															
MON															
TUE															
WED															
THU															
FRI															
SAT															
WEEKLY TOTAL															

Employee Signature: _____

Hospital Representative Signature: _____

TIME CARDS ARE DUE IMMEDIATELY FOLLOWING LAST SHIFT OF THE WEEK.

Hospital Rep. Initials Required for any OT Hours (over 40/week)