ALLIANCE SERVICES, INC

Your Complete Healthcare Staffing Partner

Time Card

910 South Main Street
West Bend, WI 53095

Phone: 262 – 677 – 2180
Fax: 262 – 677 – 3822

EMPLOYEE NAME (PLEASE PRINT)	
HOSPITAL NAME (PLEASE PRINT)	
WEEK ENDING (SAT) MONTH | DAY | YEAR	**Assigned To**: (Check One) _____ER _____Tele _____Med.Surg _____ICU _____Intermediate _____ Mom/Baby _____ L&D _____LTC _____Other

TIME SHEET MUST BE FAXED BY MONDAY NOON

Days	Date	Start Time	Lunch Time	Finish Time	Total Hours	Hospital Signature
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						

You must state your lunch time. It is required by law to take a 30 minute break when working an 8 hour shift. NO LUNCH must be approved and signed by hospital.

Employees are responsible and will be charged for no shows and late cancellations.

By signing below, I certify that I have worked the hours listed on this time sheet, and I will abide by the rules, procedures and policies referenced in the employment application.

Any overtime MUST have prior approval before working!

EMPLOYEE SIGNATURE_____