



# WEEKLY TIMESHEET

Timesheet should be submitted after your last shift for the week.

EMAIL/TEXT payroll@armstaffing.com  
or FAX 610-841-0755

Print Clearly

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

RN  LPN  CNA  Other \_\_\_\_\_

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

DATE	START TIME	AM PM	END TIME	AM PM	BREAK (MINS)	TOTAL HOURS TO BE PAID	UNIT	SUPVR. SIGNATURE / MISC. NOTES	
SUN									
MON									
TUE									
WED									
THU									
FRI									
SAT									
<b>Notes:</b>					<b>Weekly Total</b>				

EMPLOYEE ACKNOWLEDGEMENT - I certify that the above hours are a true representation of my time worked and that I have obtained an authorized signature from a facility/client representative. I certify that no injury was incurred by me during this assignment.

Employee Signature: \_\_\_\_\_  
 Print Name Sign Date

CLIENT ACKNOWLEDGEMENT - I, an authorized agent of the facility/client listed above certify that the hours listed are correct and that the employee performed their duties in a satisfactory and professionally competent manner. I certify that the hours shown above are correct.

Authorized Facility Signature: \_\_\_\_\_  
 Print Name Sign Date

