C.O.R.E. Respiratory Services™

FAX: 952-435-6985

WEEKLY TIME SHEET

This sheet must be filled out and signed by employee. All notations should be made in ink and the employee and shift supervisor/lead therapist must initial any corrections.

Employee Name: _____ Department:_____

Employee Number: _____ Facility: _____

Week Ending _____/_____/_____	Day Shift	Evening Shift	Night Shift	Overtime	Total Reg. Hrs	Total Overtime Hrs	Supervisor's Signature/ Initials
Sat.							
Sun.							
Mon.							
Tues.							
Wed.							
Thurs.							
Fri.							
Weekly Totals							

Employee's Signature: _____ Date: _____/_____/_____

Manager's Signature: _____ Date: _____/_____/_____

Fax Original to CORE Respiratory Services * One Copy to Hospital *One Copy to Employee