Peak Nursing Team, Inc.

www.peaknursing.com
Tel: 303.300.3455 • Fax: 303.512.0125

EMPLOYEE TIME CARD

Employee Name ______________________________

CLIENT/FACILITY NAME ______________________________

☐ PCP ☐ HHA ☐ CNA ☐ RN ☐ LPN

DATE		SHIFT WORKED	LUNCH BREAK	START TIME	STOP TIME	TOTAL HOURS TO BE BILLED AND PAID	UNIT OR AREA
SUN		D E N					
MON		D E N					
TUE		D E N					
WED		D E N					
THU		D E N					
FRI		D E N					
SAT		D E N					
*Time To Nearest 1/2 Hour			Weekly Total				

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 recognize the rights Peak Nursing Team, Inc. as the employer and agree not to employ or encourage employment of the above Peak Nursing Team, Inc. employee for a period of ninety (90) days following the completion of any assignment. I further agree to comply with the terms of the Client Rate Schedule/Agreement and additional terms listed on the reverse side of this document

Client/Facility Representative Signature: ______________________________

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 recognize the rights of Peak Nursing Team, Inc. as the employer and agree not to be employed by the facility individually or through an agent for a period of ninety (90) days following the termination of this assignment without approval of Peak Nursing Team, Inc. I certify that no injury was incurred by me during this assignment.

Employee Signature: ______________________________

Peak Nursing Payroll runs from Sunday to Saturday
All timecards must be submitted by 5pm on Monday
Fax 303-512-0125

white copy - Facility   yellow copy - Peak Nursing

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