Advena
HEALTHCARE STAFFING

Week Of: _____ ***Print Employee Name:*** _____

On-Call 24/7: 785-789-3944

Day	Date	Facility / Location	Position Worked	Time IN	Time OUT	Meal Break	Hours Worked	Total Miles	BONUS	Supervisor Signature
Sun			RN CMA LPN CNA	AM PM	AM PM					
Mon			RN CMA LPN CNA	AM PM	AM PM					
Tues			RN CMA LPN CNA	AM PM	AM PM					
Wed			RN CMA LPN CNA	AM PM	AM PM					
Thur			RN CMA LPN CNA	AM PM	AM PM					
Fri			RN CMA LPN CNA	AM PM	AM PM					
Sat			RN CMA LPN CNA	AM PM	AM PM					

Client Notes: *By execution of the form, Client Certifies: (1) the above hours are correct, and the work was completed in a satisfactory manner. (2) Client agrees to pay for services provided by above mentioned Employee of Advena Healthcare Staffing.*

Employee Acknowledgment: ***I certify that the hours shown above represent my total hours worked and they were verified by the facility or by an authorized representative.***

Employee Signature: _____

Employee Reminders:

- ✓ Timesheets are due on Monday by 12pm
- ✓ Submit Timesheet by:
- ✓ Email: timesheets@advenagroup.com OR
- ✓ Fax: 785-789-4756
- ✓ Submit a new timesheet for each pay period (Sunday-Saturday)
- ✓ Leave a copy of your timesheet at the facility after each shift