HOB HANDS OF BLESSING AGENCY

Name:_____

# TIME SHEET

☐ RN ☐ RPN ☐ PSW

| Date (D/M/YY) | Facility | Floor | Start Time | End Time | Total HRS | Charge Nurse Name | Signature |
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NOTE: Please email (info.hobpayroll@gmail.com) your time sheets to avoid delays, late time sheets are paid on the next pay period.
Extra hours worked MUST be approved in writing by the in-charge Nurse/DOC
You Must sign the facility register, otherwise the agency will not able to pay you.