SOUTHEAST HOMECARE

3125 West Commercial Blvd., Suite 110
Fort Lauderdale, FL 33309
Ph: (954) 615-6200

Payor Source

Insurance

NAME OF CLIENT | CLIENT I.D. | WEEK ENDING

ADDRESS | CITY | STATE | ZIP

EMPLOYEE AND NUMBER | CLASSIFICATION | LICENSE

Employee: This form is your responsibility. You cannot be paid without a Time Sheet, your signature and client's. Your Nursing Therapy Notes must accompany this Time Sheet.
EMPLOYEE SIGNATURE

X_____

I certify that the hours are my total hours worked during the week and they were properly verified by the client.

DAY	DATE MO/DAY	TIME IN	TIME OUT	TOTAL HOURS	TYPE SERVICE	CLIENT'S INITIALS
MON						
TUE						
WED						
THU						
FRI						
SAT						
SUN						

Total Hours for Week to Nearest 1/4

_____

Client recognizes the rights of Agency as the employer and agrees not to employ personnel hereon for a period of 90 days following the termination of this assignment. In the event Client violates the above condition, Client shall pay to Agency upon demand the sum of $1,000.00 in liquidation damages.

I certify that the above hours are correct and that the work was performed in a satisfactory manner by Southeast Homecare and agreement by the client to the Terms and Conditions printed above.

Authorized Client's Signature: