



Trinity United, LLC DBA Trinity Nursing Staff

785-342-3695

WEEK: _____ EMPLOYEE: _____
(Print Name)

MAKE A COPY AT THE END OF EACH SHIFT FOR FACILITY

TIMESHEETS ARE DUE BY SUNDAY 11:59PM

DAY	FACILITY	DATE	TITLE	TIME IN AM or PM	30 MIN BREAK Y or N	TIME OUT AM or PM	TOTAL HOURS WORKED	TOTAL ROUNDTRIP MILEAGE	SUPERVISOR SIGNATURE
SUN									
MON									
TUES									
WED									
THURS									
FRI									
SAT									

I CERTIFY THAT THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS WORKED AND ARE VERIFIED BY THE FACILITY OR AUTHORIZED REPRESENTATIVE.

USE ONE TIMESHEET PER WEEK. EMPLOYEE SIGNATURE: _____

IMPORTANT FOR THE CLIENT: BY EXECUTION OF THIS FORM, CLIENT CERTIFIES: 1.) THE ABOVE HOURS ARE CORRECT AND THE WORK WAS DONE IN A SATISFACTORY MANNER. 2.) AGREES TO PAY FOR SERVICES PROVIDED BY ABOVE MENTIONED EMPLOYEE OF TRINITY UNITED, LLC.

EMAIL TIMESHEET TO: PAYROLL@TRINITYUNITEDLLC.COM