ASSOCIATE TIMESHEET

Associate Name_____

Client Name_____

****Timesheets are to be completed in their entirety, signed, and submitted to HealthStaff no later than 8am on the Monday following the end of a workweek. Email to timesheets@yourhealthstaff.com, OR *upload to the mobile staffing app*, as applicable. Please submit a separate timesheet for each client.****

	Date	Time In	Meal Break Time Out	Meal Break Time In	Time Out	Total Hours (optional)	HS Admin Use Only (Rounding, total hrs, notes, etc.)
Example	1/12/23	7:43a	12:01p	1:15p	05:02	8hrs 5min	(7:45)-(5:00) less (75min) = (8.0hrs)
Mon							
Tues							
Wed							
Thurs							
Fri							
Sat							
Sun							
					Total Hours for the Week:		

I certify that I worked the hours reported on this timesheet during the week indicated above, I have not been asked to perform work that is unsafe or unlawful, and I did not experience any accident or injury that I did not report directly to HealthStaff. I understand my times will be rounded to the nearest 15 minutes using the 7-minute rule, in accordance with federal and state law. I understand that submission of fraudulent timesheets may be subject to termination as well as civil and criminal prosecution.

Associate Signature_____ Date_____

Client Use Only:

By signing below, I, the Authorized Client Representative certify that: (1) this timesheet has been audited by the client and the worked hours reported on this timesheet are correct, (2) the work was performed in a satisfactory manner, (3) there was no known accident or injury to the associate that was not reported to HealthStaff, and (4) HealthStaff is authorized to bill Client by the terms of the most current signed Client Staffing Agreement or the Client Master Services Agreement and Client Terms of Service Agreement for the work performed by the named associate. I understand that the associate's times will be rounded by HealthStaff to the nearest 15 minutes using the 7-minute rule for invoicing. I recognize the rights of HealthStaff as the employer and agree not to pay the associate directly or to employ directly in any capacity the person named herein. By signing below, I confirm that I am authorized to approve time and that HealthStaff may rely upon my signature as binding on behalf of the Client.

Authorized Client Rep. Name (print)_____ Title_____

Signature_____ Date_____