


EMPLOYEE NAME		SOCIAL SECURITY NUMBER					CLIENT NAME				
		XXX	XX								
DAY	DATE	SHIFT START	SHIFT FINISH	BREAK/LUNCH	TOTAL HOURS	CLIENT INITIAL	Regular Time	Military Time	Regular Time	Military Time	
RN							Midnight	0000	Noon	1200	
LPN							1:00 a.m.	0100	1:00 p.m.	1300	
CMA							2:00 a.m.	0200	2:00 p.m.	1400	
CNA							3:00 a.m.	0300	3:00 p.m.	1500	
							4:00 a.m.	0400	4:00 p.m.	1600	
							5:00 a.m.	0500	5:00 p.m.	1700	
							6:00 a.m.	0600	6:00 p.m.	1800	
							7:00 a.m.	0700	7:00 p.m.	1900	
							8:00 a.m.	0800	8:00 p.m.	2000	
							9:00 a.m.	0900	9:00 p.m.	2100	
							10:00 a.m.	1000	10:00 p.m.	2200	
							11:00 a.m.	1100	11:00 p.m.	2300	
WEEKLY TOTAL HOURS							CLIENT SIGNATURE	X			

I certify that the hours shown were worked by me during the week indicated. I understand I must contact the Tri-State Nursing office within 3 days of last scheduled shift.


EMPLOYEE SIGNATURE X _____

MAIL OR DELIVER TO:  800-727-1912
 3100 S. Lakeport St. • Sioux City, IA 51106
 712-277-4442 • Fax 712-255-6840

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