

Helping Hands Healthcare Intermittent Weekly Time Sheet

| | | |
|-------------------|-------------|--------|
| Nurse Name/ Title | Week Ending | Number |
|-------------------|-------------|--------|

EMPLOYEE: I certify that the time worked as show is true, accurate, and worked by me during the days in the indicated week and was properly certified by the client or client's representative on the nursing note corresponding to the date and time.

| | Client Name | Date | Time Started | Time Finished | Total Hrs | Comments |
|----|-------------|------|--------------|---------------|-----------|----------|
| 1 | | | | | | |
| 2 | | | | | | |
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| 24 | | | | | | |

EMPLOYEE SIGNATURE: _____