

HELPING HANDS

WEEKLY TIME SHEET

Client Name	Week Ending	Number
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EMPLOYEE: I certify that the time worked as shown 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 at the bottom of this form.

CLIENT: I certify that the HELPING HANDS HEALTHCARE employee worked the times indicated and that the work was performed in a satisfactory manner.

	Employee Name	RN/LPN	Date	Time Started	Time Finished	Total Hrs	Comments
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2							
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CLIENT SIGNATURE: _____