



**Nurses-Kansas, LLC**

*Nursing Excellence. Every Shift.*

1117 Washington St. • Great Bend, KS 67530  
(620) 793-7262 • 1-877-530-7262

**EVERY PART OF THIS SLIP MUST BE COMPLETED  
IN ORDER TO BE PROCESSED FOR PAYMENT  
SUBMIT ALL TIME SLIPS BY MONDAY 8:00AM - THANK YOU!**

**37472**

Employee Name \_\_\_\_\_ (Circle One) RN LPN CMA CNA

Client Facility \_\_\_\_\_ Area Worked \_\_\_\_\_

Did this shift include an overnight stay? **(THIS MUST BE COMPLETED)**

NO \_\_\_\_\_ Motel/Date Check In \_\_\_\_\_ Depart Date/Time \_\_\_\_\_

Shift Start Date: \_\_\_\_\_ Shift Time: Arrival/Start \_\_\_\_\_ Depart/End \_\_\_\_\_

No Lunch: \_\_\_\_\_ Client Initials: \_\_\_\_\_

Overtime Hours: \_\_\_\_\_

**TOTAL HOURS:** \_\_\_\_\_

Round Trip Mileage: **(This must be completed or reimbursement is forfeited)** \_\_\_\_\_

Day **(You must circle the day your shift started)** Sun Mon Tues Wed Thurs Fri Sat

Client Signature \_\_\_\_\_ **(A copy will be sent to you with an invoice)**

**Execution of this form by the client constitutes a certification that the total hours listed are correct as stated.**

*White Copy: Q.S. Nurses*

*Yellow Copy: Employee*

*Pink Copy: Facility*