1701 Williams Street
Great Bend, KS 67530
620 793 7262
Fax 620 793 7232
staffing@qsnurses.com

Employee: _____ (circle) RN LPN CMA CNA

Facility: _____

Shift Date: _____ Unit: _____

EXTRA PAY:
Short Notice $_____
Other $ _____

Start Time: _____ _____ : _____ _____

Meal Break: 0 0 : 3 0 Yes ____ No ____

End Time: _____ _____ : _____ _____

Total Hours: _____ _____ : _____ _____ Mileage: _____

FACILITY USE ONLY:

No Meal Break Approval: _____
Missed meal break must be authorized by signature.

Client Approval Signature: _____
(A copy will be sent to you upon request)

Make a copy of this timesheet and provide to the facility at the end of each shift.
Complete immediately after shift and upload to WFP.

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