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

Team Member: _____ (circle) RN LPN CMA CNA

Facility: _____

Shift Date: _____ Unit: _____

Start Time: _____ : _____

Meal Break: 0 0 : 3 0 Yes____No ____

End Time: _____ : _____

Total Hours: _____ : _____ Mileage: _____

EXTRA PAY? (Check the box)

Short Notice ☐

Hazard/COVID ☐

Other ☐

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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