

NURSE MANAGEMENT SERVICES OF GEORGIA, INC.

P.O. Box 688
Hampton, Georgia, 30228
Office Phone (770) 991-6645 Fax (770) 991-6972

EMPLOYEE TIME SHEET

Client's Name: _____

Employee Name: _____

SS# (ID): _____

Week Beginning: _____ Week Ending: _____

Date	Day	Time In	Time Out	Client's Initials
	Sunday			
	Monday			
	Tuesday			
	Wednesday			
	Thursday			
	Friday			
	Saturday			

TOTAL HRS WORKED	
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I certify the hours recorded above are correct

Employee Signature **Date**

I acknowledge this is an accurate recorded time in Nurse Mgmt Services of Ga, Inc., Inc. provided services and that no injuries occurred during this time to the employee or the client.

Client Signature **Date**

ALL OVERTIME MUST BE PRE-AUTHORIZED BY THE Nurse Mgmt Services NURSING OFFICE

PLEASE USE INITIALS TO DOCUMENT ACTUAL DUTIES PERFORMED FOR THE CLIENT. WRITE IN THE NARRATIVE NOTE ANY CHANGES IN THE CLIENTS NURSING OBSERVATIONS ONLY.

THIS IS A LEGAL DOCUMENT

Narrative Notes: _____

Date: _____ Date: _____

Date: _____ Date: _____

*Employee cannot receive payment until a **signed** time sheet is received. Employee and client must sign time sheet and verify all hours and service*

A Separate time sheet for each week and each client must be completed. In other words, please do not combine different pay periods and / or clients onto one time sheet, as this may cause delays and/or errors in your paycheck. Time sheets must be mailed and faxed in weekly by Monday at 12noon in order to receive payment for services rendered, a time sheet that is turned in late, will be paid the following week. ORIGINAL TIMESHEETS MUST BE RECEIVED IN OFFICE BY THE END OF EACH MONTH.

Services Provided	S	M	T	W	Th	F	S
Assess / Assure Hygienic Care Compliance							
Nail Care							
Bath: Bed Bath <input type="checkbox"/> Shower <input type="checkbox"/>							
Hair Care: Brush Hair <input type="checkbox"/> Shampoo <input type="checkbox"/>							
Mouth Care <input type="checkbox"/> Denture Care <input type="checkbox"/>							
Skin Care <input type="checkbox"/> Shave <input type="checkbox"/>							
Dressing/Undressing							
ASSESS / MONITER HOME CLEANINESS							
Cleanliness of living areas <input type="checkbox"/>							
Kitchen area <input type="checkbox"/> Bedroom areas <input type="checkbox"/>							
Evaluate Safety Factors In The Home							
Observing/ Reporting changes in client condition							
<input type="checkbox"/> Laundry							
<input type="checkbox"/> Grocery Shopping							
Trash Removal							
Picking up /Arranging for prescriptions refill							
Change Linens <input type="checkbox"/> Make bed <input type="checkbox"/>							
Watchful Supervision and Oversight							
Encouraging Proper Nutrition							
Meal Preparation <input type="checkbox"/> Feed <input type="checkbox"/>							
Assisting with food stamp and other application							
Reminding Client to take Medications <input type="checkbox"/> Family Administered Meds <input type="checkbox"/>							
Monitor oxygen use							
Arranging transport. to appointment <input type="checkbox"/> Family to transport <input type="checkbox"/>							

REVIEWED