

# 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 Signature
	Sun			
	Mon			
	Tues			
	Wed			
	Thurs			
	Fri			
	Sat			

<b>TOTAL HRS WORKED</b>	
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I certify the hours recorded above are correct

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**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.

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**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 or dropped off weekly on Monday by 12 noon in order to receive payment for services rendered. Any time sheet that is turned in late, will be paid the following week. ORIGINAL TIMESHEETS MUST BE RECEIVED IN OFFICE EVERY MONDAY. NO COPIES ACCEPTED. CLIENTS WITH ID#40...ONLY! MUST BE FAXED BEFORE MAILING EACH WEEK.***

Services Provided	S	M	T	W	Th	F	S
<b>Assess / Assure Hygienic Care Compliance</b>							
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							
<b>ASSESS / MONITER HOME CLEANINESS</b>							
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							
<b>Encouraging Proper Nutrition</b>							
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