

Emp. No. _____

DAY	DATE	SHIFT START	SHIFT FINISH	SOCIAL SECURITY NUMBER			INITIAL	SHIFT			BILL HOURS
				LESS OFF DUTY	TOTAL HOURS						
MON											
TUES											
WED											
THUR											
FRI											
SAT											
SUN											
WEEKLY TOTAL HOURS											CLIENT SIGNATURE X

Dept. No. _____

I certify that the hours shown were worked by me during the week indicated. I understand I must contact the Tri-State Nursing office within 3 days of last scheduled shift.

EMPLOYEE SIGNATURE X _____

MAIL OR DELIVER TO: **Tri-State Nursing** 800-727-1912
 621 16th St. • Sioux City, IA 51105 • 712-277-4442 • Fax 712-277-4547
 521 Michigan Street • Storm Lake, IA 50588 • 712-213-3500 • Fax 712-213-3502
 7701 Pacific St. Suite 122 • Omaha, NE 68114 • 402-502-1610 • Fax 402-502-1620
 5701 S. Western Ave. Suite 104 • Sioux Falls, SD 57108 • 605-221-0850 • Fax 605-221-0853
 200 E. Kemp Ave. • Watertown, SD 57201 • 605-753-7530 • Fax 605-753-7534

White - Office
Yellow - Client
Pink - Employee

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