



**EMPLOYEE NAME:** \_\_\_\_\_  
*Please print clearly*      **LAST NAME**      **FIRST NAME**

1485 International Parkway  
 Suite 2051  
 Heathrow, FL 32746

**FACILITY NAME:** \_\_\_\_\_  
*Please do not abbreviate*

Phone: 800-798-6035  
 Fax: 888-235-6035

**TIMESHEET *MUST* BE RECEIVED BY  
 VOYAGE HEALTHCARE NO LATER THAN  
 NOON EST MONDAY**

**PLEASE FAX TO 888-235-6035**

	DATE	TIME IN	LUNCH	TIME OUT	TOTAL HOURS
MONDAY			:		
TUESDAY			:		
WEDNESDAY			:		
THURSDAY			:	:	
FRIDAY			:		
SATURDAY			:		
SUNDAY			:		
<b>*TOTAL HOURS FOR WEEK:</b>					

- Your Timesheet is complete when:**
- 1) Date/Hours are filled in clearly (round to the quarter hour, no military time)
  - 2) Facility name is written in clearly (Please do not abbreviate)
  - 3) Employee name is written clearly (Last Name, First Name)
  - 4) Bottom section completed and signed by both client and employee
  - 5) Timesheet is completed and faxed to 888.235.6035 by Monday @ Noon

**\*If total hours do not equal 40, please indicate why below:**

- Facility dismissed early
- Sick
- Planned/Requested time off
- Other \_\_\_\_\_

**Failure to fully complete timesheet with all required information may result  
 in a delay in your payroll being processed**

**\*\*\*This section must be filled out completely prior to faxing to Voyage Healthcare\*\*\***

Facility Authorization: Please verify and write in approved hours	Regular Hours	Overtime Hours	Holiday Hours	
				Please Initial
<b>JOINT COMMISSION REQUIREMENT</b>				
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<b>Employee has satisfactorily completed work</b>		
If No, Please contact Voyage Healthcare at 800-798-6035				
<b>Client Representative (please print):</b> _____				
<b>Client Signature:</b> _____ <i>Client agrees to be invoiced the hours verified on this timesheet</i>				
<b>Therapist Signature:</b> _____ <i>I certify that the hours shown represent my total hours and were verified by an authorized representative</i>				