



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			:		
*TOTAL HOURS FOR WEEK:					

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

Client Representative (please print): _____

Client Signature: _____
Client agrees to be invoiced the hours verified on this timesheet

Therapist Signature: _____
I certify that the hours shown represent my total hours and were verified by an authorized representative