ENVISTA
HEALTHCARE STAFFING

Each Sunday, please fax this timesheet to: 315-660-7513 or email: pay@envistahealth.com

Employee's Name:		**Service to:**							
	Date:								TOTAL
		SUN	MON	TUES	WED	THUR	FRI	SAT	
Employee's Signature/Date	**In**								
	Out								
	In								
	Out								
	Regular hours								
	Charge Hours								
	Call Back Hours								
	On Call Hours								
	Guaranteed Hours:								
Manager/Supervisor Signature	**If your worked hours are less than guarantee, indicate reason (ie.-Schedule, sick, time off, etc.) If reason is not indicated you will be paid for hours worked and guarantee will not apply.**								
Printed Name of individual authorizing timesheet	**Comments:**								

I agree the time reported is accurate and the work was performed satisfactorily.

To be paid, this timesheet must contain:

1. The correct week begin date

2. *Readable* and accurately entered hours: example 7 1/4 hours = 7.25

3. Your signature/date

4. Manager's signature/date

5. MUST BE FAXED OR EMAILED WITH MANAGERS SIGNATURE NO LATER THAN 12:00 PM EST EACH SUNDAY!

Do not change this form. Failure to complete correctly will cause payment delay