

Employee Name: \_\_\_\_\_  
 (Please Print)

For the Period of: \_\_\_\_\_

Facility: \_\_\_\_\_  
 ( Please use a different time sheet for each facility. )



VisionQwest Healthcare  
 500 N. Central, Suite 740  
 Glendale CA 91203  
 Phone: 818.547.0497  
 E-Mail: accounting@vqrginc.com

**Fax time sheets to: (310) 861.5558**

Completed timesheets must be submitted to the Accounting Department **no later than 12 noon on day following pay period ending shift** of each week to be paid.  
**All Items on Time Sheet Must Be Completed Accurately for the Accounting Department To Issue A Paycheck.**

Date	Day	Unit	Time-In	Time-Out	Lunch	Actual Hrs. Worked	Over Time Hours	Double Time Hours	Holiday Hours	Misc.	OVERTIME APPROVED BY CLIENT	
	Sun										YES	NO
	Mon										YES	NO
	Tues										YES	NO
	Wed										YES	NO
	Thurs										YES	NO
	Fri										YES	NO
	Sat										YES	NO
	Sun										YES	NO
	Mon										YES	NO
	Tues										YES	NO
	Wed										YES	NO
	Thurs										YES	NO
	Fri										YES	NO
	Sat										YES	NO
<b>Total Hours:</b>												

I CERTIFY THAT NO ACCIDENT OR INURY WAS SUSTAINED BY ME WHILE WORKING ON THE ASSIGNMENT UNLESS SO NOTED ABOVE. I CERTIFY THAT THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS WORKED ON THIS ASSIGNMENT, AND THAT THEY WERE PROPERLY VERIFIED BY THE CLIENT'S AUTHORIZED REPRESENTATIVE

Employee Signature: \_\_\_\_\_

I CERTIFY THAT THE HOURS SHOWN ABOVE ARE CORRECT AND WORK WAS PERFORMED IN A SATISFACTORY MANNER.

CLIENT SIGNATURE \_\_\_\_\_