QUALITY TEMP STAFFING
MEDICAL STAFFING SPECIALISTS

EMPLOYEE TIMESHEET

Employee Name: _____ **Job Title:** _____

Facility Name: _____ **Pay Period:** _____

WORK DAY	DATE	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	OVERTIME IN	OVERTIME OUT	BREAKS (CHECK OFF)		REG HOURS	OT HOURS	OT INITIAL
Sun.												
Mon.												
Tues.												
Wed.												
Thurs.												
Fri.												
Sat.												
									Week Total:			

WORK DAY	DATE	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	OVERTIME IN	OVERTIME OUT	BREAKS (CHECK OFF)		REG HOURS	OT HOURS	OT INITIAL
Sun.												
Mon.												
Tues.												
Wed.												
Thurs.												
Fri.												
Sat.												
									Week Total:			

WORK DAY	DATE	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	OVERTIME IN	OVERTIME OUT	BREAKS (CHECK OFF)		REG HOURS	OT HOURS	OT INITIAL
Sun.												
Mon.												
Tues.												
Wed												
Thurs.												
Fri.												
Sat.												
									Week Total:			

Fax or email timesheet before 9:00am to (818) 831-1126 / email@qualitytempstaffing.com

Comments: _____

I certify that I have provided complete and accurate information by signing this timesheet. I understand that it is against company policy to provide false or incomplete information on timesheets.

GRAND TOTALS:			
	Reg	**OT**	**DT**

Employee Approved Signature _____ **Date** _____

- State law a 30-minute meal period is required for every shift that is more than 5 hours.
- **Timesheets are due by 9:00am** on the 1st and the 16th day of each month.
- Overtime is paid in excess of 8 hours per day and over 40 hours per week.
- Please complete a NEW timesheet for each facility.

Facility Supervisor Approved Signature _____

QTS Payroll Department Approved Signature _____

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