



INTEGRATED

EMPLOYEE NAME: _____ FACILITY NAME: _____

Certification	RN	LPN	CNA	Other	Paycheck	HOLD	MAIL
DATE	UNIT	START TIME	LUNCH	END TIME	TOTAL HOURS		

I certify that the hours above are correct and that the employee performed his/her duties satisfactorily. I understand that I do not pay the employee directly and that INTEGRATED will pay the employee weekly. I agree to comply with the terms on the back of this timecard as well as the terms of any Facility Staffing Agreement executed by my company/facility and INTEGRATED.

SUPERVISOR SIGNATURE: _____ DATE: _____
PRINTED NAME: _____ NO LUNCH PERMITTED: _____

Supervisor
Initials

I certify that the hours shown above represent my total hours worked.

EMPLOYEE SIGNATURE: _____