

TIMESHEET / INVOICE

Agency Name: _____

Invoice #: _____

Date: _____

Nurse Details:

Name: _____

ID/License: _____

Phone: _____

Facility Details:

Name: _____

Department: _____

Ward/Unit: _____

Date	Shift Type	Start Time	End Time	Break (min)	Total Hours	Rate	Total

GRAND TOTAL: \$ _____

Nurse Declaration:

I certify that the hours logged above are accurate and no injuries were sustained during these shifts.

Nurse Signature

Facility Authorization:

I certify that the above hours were worked and the performance was satisfactory for payment.

Authorized Manager Signature & Stamp