Client and Healthcare Professional should retain a copy.

PLEASE FAX A COPY TO SPECIALTY 718-225-9421
Hours Must Be Received by 5pm (EST) every Monday to be paid that week.
Please Call the office to confirm receipt

SPECIALTY
PROFESSIONAL SERVICES

TIME SHEET

Page #:	
Client:	
Week Ending Date: / /	

218-14 Northern Boulevard Suite 205 Bayside NY 11361
Phone: 718-428-3600 • Fax 718-225-9421• www.TheSpecialty.com • E-Mail: payroll@thespecialty.com

DAY m,t,w,th,f,sa,su	DATE	UNIT WORKED	PRINT NAME	SKILL RN/LPN …	Soc Sec # Last 4 digits	SIGNATURE	TIME IN	TIME OUT	MEAL BREAK	TOTAL HOURS (Billable)	CLIENT INITIALS
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						
					xxx-xx-						

Authorized Client Signature:_____ Title: _____ Date: _____

Employee certifies by signing this that the hours shown above represent the total hours worked and were properly verified by the client or an authorized representative.
Employee also agrees that no injury was sustained by me while working on assignment unless noted above.
Client certifies that the Employee performed their duties correctly and in a satisfactory manner.