CONSUMER / CLIENT NAME _____ **TriMED HEALTHCARE, LLC**

PRINT EMPLOYEE NAME_____

WEEK START DATE (SATURDAY)	
WEEK END DATE (FRIDAY)	

CLASSIFICATION RN LPN DCW/PCA HM Other_____

TIME SHEET

DAY	DATE	START TIME	FINISH TIME	TOTAL TIME LESS BREAK	AUTHORIZED CONSUMER SIGNATURE
SAT					
SUN					
MON					
TUE					
WED					
THU					
FRI					
		TOTAL	HOURS		

CONSUMER NOTE: By your signature, you certify that hours shown are correct, work was completed satisfactorily, and you agree to the terms listed below**. It is understood that overtime at 11/2 times will be billed for over 40 hours a week**

EMPLOYEE NOTE: By your signature, you certify that the hours recorded for the above dates are true and accurate and are properly verified by the client. A reminder that designated holidays and supervisor approved overtime are 11/2 times the regular rate.

_____ _____/____/____

Employee Signature **Date**

CONDITIONS

CONSUMER Agrees to terms of NET UPON RECEIPT, and understands that unpaid amounts will be considered in default after 15 days, after which a default charge will be imposed at 11/2 % per month on unpaid balances (Annual rate of 18%) or the legal interest, whichever is lower. Consumer agrees to pay the default together with a reasonable attorney's fee for the cost of collection.

CONSUMER recognizes the rights of TriMED Healthcare, LLC as the employer and agrees not to employ the person named herein for a period of 180 days following termination of this assignment unless and assessment fee has been paid. The fee is $3000 for individuals. And 25% the projected annual wage for facilities. Do not pay the employee directly. No credit can be assured against a current invoice. Employee BONDING claims are only assured if claims are made in writing and to the local police within 14days after notice of loss.

AIDE ACTIVITY RECORD

Directions: This is a legal document. Carefully check the assignment/care plan. Initial activities completed. Clinical observations should also be called to the service coordinator or the nursing supervisor.

Place a check.√ under date of care.

	DATE							
	DAY	SAT	SUN	MON	TUE	WED	THU	FRI
	ACTIVITY							
BATHING	BED BATH							
	TUB / SHOWER							
	PARTIAL BATH							
PERSONAL CARE	MOUTHCARE							
	DENTURES							
	HAIR CARE							
	SHAMPOO							
	EYE CARE							
	CHANGE CLOTHES							
	SHAVE							
	SKIN CARE							
	FOOT CARE							
	TOILETING							
	BOWEL MOVEMENT							
	INCONTINENCE CARE							
	CATHERTER CARE							
AMBULATION	AMBULATE							
	TURN & POSITION							
	BED BOUND/ SIDE RAILS							
	TRANSFER – CHAIR-							
	TRANSFER -COMMODE							
EXERCISES	ROM / EXERCISE							
	WENT FOR WALK							
MEAL PRERATION	GROCERY SHOP							
	PREPARE MEAL /							
	FEED/ASSIST EATING							
	DIET INSTRUCTIONS							
	APPETITE (DESCRIBE)							
	FORCE FOODS/FLUIDS							
	ENCOURAGE FLUIDS							
	RECORD INTAKE / OUTPUT							
HOUSE KEEPING	LAUNDRY/LINEN							
	CLEAN BATHROOM,							
	CLEAN STRIGHTEN RM							
	CLEAN EQMT, KITCHEN							
OTHER	MEDICATION REMINDER							
	SOCIALIZATION							

Signature Required for Each Day of	SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Consumer / Client Signature							
Employee Signature							