



CHESAPEAKE
MEDICAL STAFFING

FAX (410) 321-4980

Time slip must be faxed in by Monday morning for weekly payroll

Hospital (Client): _____

CMS Associate Name: _____ RN / Rad. / CNA / RCP

CMS Associate Signature: _____

| Shift Start Date MM/DD/YY | Shift Worked | Start Time | Finish Time | Reg. Hours | OT Hours | Authorized Hospital/Client Signature | Unit or Floor |
|------------------------------|--------------|------------|-------------|------------|----------|--------------------------------------|---------------|
| | D E N | | | | | | |

***30 minute break will be deducted from each shift greater than six hours.

Nursing Supervisor / Dept. Manager approval (printed name and initials) is required for all hours worked in excess of scheduled shift.

Print Supervisor Name: _____

Supervisor Initials: _____

Use this section to give a brief explanation for any excess time worked:

2401 York Rd., Timonium, MD 21093 • Phone (410) 321-4267



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Associate Name _____ **RN / Rad. / RCP / CNA**

Associate Signature _____

Hospital / Client _____

| Day | Date | Shift | Start Time | Finish Time | Reg. Hours | OT Hours | Authorized Hospital/Client Signature | Unit/Specialty |
|--------------------|------|-------|------------|-------------|------------|----------|--------------------------------------|----------------|
| SUN | | D E N | | | | | | |
| MON | | D E N | | | | | | |
| TUE | | D E N | | | | | | |
| WED | | D E N | | | | | | |
| THU | | D E N | | | | | | |
| FRI | | D E N | | | | | | |
| SAT | | D E N | | | | | | |
| TOTAL HOURS | | | | | | | | |