AMERICAN CRITICAL CARE SERVICES

P.O. Box 35717 * N. Chesterfield, Va. 23235
Phone: (804) 320-1113 Toll Free: (800) 245-4011
Fax: (804) 330-9460

* All timeslips are processed for payroll at the corporate office in Richmond, Va.

*Time slips should be faxed or mailed to Richmond .

*Time slips are due no later than 9:00 a.m. on Tuesday

EMPLOYEE NAME: ______________________ RN LPN CNA

CLIENT / FACILITY NAME: ______________________

WEEK ENDING DATE: ______________________

PLEASE CHECK ONE: ☐ Direct Deposit ☐ Check ☐ Wire Transfer ($30.00 FEE)

DAY	MONTH / DATE	START TIME	FINISH TIME	UNIT WORKED	LESS MEAL	DAILY TOTAL
Sun	___/___	am pm	am pm			
Mon	___/___	am pm	am pm			
Tue	___/___	am pm	am pm			
Wed	___/___	am pm	am pm			
Thu	___/___	am pm	am pm			
Fri	___/___	am pm	am pm			
Sat	___/___	am pm	am pm			

COMMENTS: ____________

CODE

Employee Signature:

X ______________________

I certify that the hours shown are correct and have been authorized by the client. Note: Falsification of this document for payment of salary is a criminal offense. Client signature required for compensation!

TOTAL HOURS: ______

Do not pay employees. American Critical Care Services, Inc. will not be responsible for any amount advanced to the employee. I certify that the hours listed above are correct and that I am satisfied with the service.

X ______________________ (Please Print – Client Name) ________ (Date)

X ______________________ (Client Signature) – (Required) ________ (Date)

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