Holsman Healthcare LLC
Healthcare Consulting and Rehabilitation Services
Tel: 973-759-1494 / 1877-268-9100 / 973-393-5545 Fax: 973-759-0557

TIME SHEET

NAME: _____ MONTH: _____ YEAR: _____

FACILITY:_____ DISCIPLINE: ❒OT❒ COTA ❒ PT ❒ PTA ❒ SLP

DAY	DATE	TIME IN	TIME OUT	TIME IN	TIME OUT	HOURS
SUN						
MON						
TUE						
WED						
THU						
FRI						
SAT						
SUN						
MON						
TUE						
WED						
THU						
FRI						
SAT						
					TOTAL HOURS	

1. Use a separate time record for each assignment and each client.
2. Timesheet must be signed by authorized representative of Client Company.
3. A copy of this timesheet should be given to the client, one to Holsman Healthcare, and one kept by employee.
4. Timesheets must be submitted to Holsman Healthcare by NOON on the Monday following the work week.

IMPORTANT FOR EMPLOYEE/ CONTRACTOR: By executing this form, employee/contractor certifies that the time entries on this form are true and accurate, and that EMPLOYEE/CONTRACTOR has not worked any other hours that are not set forth on this form, and that no workplace injuries were suffered during the workweek. I am further aware that I may not work overtime without the express written permission of HHC and that if I violate any of the provisions set forth herein or fraudulently record my hours I may be subject to discipline, up to and including termination. Employee/Contractor also agrees to the terms and conditions concerning EMPLOYEE/CONTRACTOR on the bottom of form.

Employee/Professional's Signature: _____

Facility Representative's Name: _____

Representative's Signature: _____

Employer's Signature: _____

PLEASE FAX TIME SHEET TO HHC EVERY MONDAY @ 973-759-0557

In consideration of my hiring and employment by Holsman Healthcare, LLC, I agree to comply with the terms of my Employment or Independent Contractor Agreement including, but not limited to, those sections that prohibit me from accepting employment directly or indirectly whether full-time or part-time either directly or indirectly through any other staffing firm or entity with any Holsman Healthcare CLIENT to whom I am assigned and for a period of One year (1 year) following completion of any assignment with such CLIENT. I agree to notify HOLSMAN HEALTHCARE, LLC immediately should I receive such an offer of employment. I agree that if I violate this provision Holsman Healthcare LLC is entitled to obtain compensatory or equitable relief against me at my expense as provided by the terms of either my Employment or Independent Contractor Agreement.