

Please fax timesheets to AMPS Payroll Department at (866) 426-2811, (407) 956-1337, or e-mail to Timesheets@Advanced-Medical.net by 5pm EST on Monday

IMPORTANT FOR FACILITY: Execution of this form by the facility constitutes a certification that the TOTAL hours are correct as stated, that the work was performed in a satisfactory manner and that the facility agrees to the Terms and Conditions of the Contract made with AMPS.

Employee Name: _____

Department Name: _____

Office Location: _____

OFFICE USE ONLY

T=

M + IE=

C=

H=

Billing:

IS=

ID=

Time sheets submitted without an authorized signature **will not be processed.**

If you are having difficulty getting your time sheet signed, please notify your recruiter immediately. Failure to notify your recruiter in a timely manner may result in delayed or unprocessed paychecks.

Please have your Floor Manager sign off each day worked. Also note on the timesheet if you were called off a shift or took personal time off.

SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

DATE WORKED (MM/DD/YY)								TOTAL HOURS
TIME IN (I.E. 8 am)								
Minutes for break/lunch (I.E. 30)								
TIME OUT (I.E. 5 pm)								
TOTAL HOURS (Less Lunch Period)								
HOME HEALTH ONLY: # of Patients Seen								
Drive Time In*:								
Drive Time Out*:								
Total Mileage*:								
For Office Use Only:								

***IF your contract specifies that you are to be reimbursed for drive time or milage, please note that information in the space above.**

Comments/Special Instructions:

Employee Signature: _____

Date: _____

FOR SUPERVISOR USE ONLY

Supervisor Name: _____

Please rate the overall quality of work for the employee:

Supervisor Signature: _____

Above Average

Average

Below Average

****If a situation occurs that makes you unable to fax the timesheet by the required time, please contact your recruiter.****