HEALTHCARE LICENSED PERSONNEL, LLC
est. 2004

FACILITY NAME: _____ INVOICE # _____

EMPLOYEE NAME: _____ DSP ___CNA ___LPN ___RN ___

DAY	DATE	START	END	BREAK	AUTHORIZED SIGNATURE
SUNDAY		AM PM	AM PM		
MONDAY		AM PM	AM PM		
TUESDAY		AM PM	AM PM		
WEDNESDAY		AM PM	AM PM		
THURSDAY		AM PM	AM PM		
FRIDAY		AM PM	AM PM		
SATURDAY		AM PM	AM PM		

EMPLOYEE SIGNATURE_____

TIME SHEETS MUST BE SIGNED EACH NIGHT BY FACILITY REPRESENTATIVE/SUPERVISOR TO BE ACCEPTED. TIME SHEETS MUST BE EMAILED TO **PAYROLL@HEALTHCARELP.NET** ***24 HOURS AFTER YOUR LAST SHIFT*** FOR WEEKLY PAYROLL. TIME SHEET Received 15 DAYS FROM LAST DAY WORKED WILL NOT BE PAID/ACCEPTED. ***Healthcare Licensed Personnel, LLC P.O.BOX 587 Koppel, PA 16136***