PER DIEM DAILY TIME FORM

EINSTEIN HEALTHCARE NETWORK

NAME:
(PLEASE PRINT)

AGENCY:

DAY	DATE	UNIT WORKED	Time In	Time Out	30 Min Meal Break		Overtime Worked	Total Hours Worked (less meal break)	CHECK IF PERFORMANCE CONCERNS
					time out	time in			
									☐

I certify that the hours shown above represent my total hours worked and that they were properly verified by an authorized representative of EHN. I certify that no accident or injury was sustained while working on the assignment unless so noted in the comment section below.

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Healthcare Worker Signature & Date

Comments:

I certify that the above named HCW has worked the hours shown on this time form satisfactorily, unless noted above. By signing this time form, I am confirming the time worked and certify that I am authorized by EHN to sign this form.

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Printed Manager Name / Title

Manager Signature

***Approval for Overtime Worked (Manager's Initials)** ☐

***All overtime hours must have manager or supervisor authorization.**