Becker

EMPLOYEE TIME CARD

For the week of

___/___/___ to ___/___/___

Email Signed Timecard at End of Shift to:
timesheets@beckertek.com
or fax to **610.934.0221**
PLEASE PRINT CLEARLY

Facility Name (one per timecard)

Employee Name

Employee Responsibility — *Timecards must be signed by an authorized representative of the facility after each shift prior to leaving the facility. Failure to do so may result in a delay in payment until the shift is signed/validated.*

Client Authorization
(INCLUDING O.T. AUTHORIZATION)
EACH SHIFT IS SEPARATE — *Being an authorized representative of the facility, the undersigned hereby: (1) Agrees that the work was performed in a satisfactory manner. (2) Agrees that the hours stated are correct. (3) Agrees to pay overtime on all hours worked in excess of 40. (4) Agrees to pay the related invoice in full within 30 days of the invoice date.*

SHIFT START DATE		SHIFT START TIME		SHIFT END TIME		DEDUCT MANDATORY BREAK		SUPERVISOR (print name)	SUPERVISOR (signature)
DAY OF THE WEEK	DATE MM/DD/YY	HH : MM	AM OR PM (circle one)	HH : MM	AM OR PM (circle one)	MINUTES (circle one)	NO BREAK (initial)		
SUN	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
MON	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
TUE	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
WED	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
THU	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
FRI	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			
SAT	/ /	:	AM / PM	:	AM / PM	15 30 45 60			
		:	AM / PM	:	AM / PM	15 30 45 60			

I certify that the hours shown are correct and represent the total hours I worked at this facility for the week. An authorized client representative properly verified these hours. I understand that any misrepresentation of hours worked or failure to obtain the signature of an authorized client representative will be considered an attempt to commit fraud and will be prosecuted to the fullest extent allowed under state law. I understand that any questionable or illegal information or signatures on this document are subject to verification by Becker Health which may cause a delay in processing. I understand that I will be paid upon verification of the above information.

EMPLOYEE SIGNATURE

DATE