

A new timesheet should be used for each visit.



PATIENT NAME

START VISIT

EMPLOYEE'S NAME

END VISIT

PATIENT ADDRESS

Notes:

EMPLOYEE: Execution of this timesheet is your responsibility. You cannot be paid unless the timesheet is signed by you and the client company.

I agree to the terms of Ampm Home Healthcare service contract and pay interest on unpaid balances. At the contractual rate or the maximum amount allowed under the state law, together with all collection and litigation costs plus interest, reasonable attorney's fees, and legal expenses, incurred by Ampm Home Healthcare Service, in connection with the collection of such amounts, within the limits provided by applicable state law. I agree to pay Ampm Home Healthcare staffing placement fees, if I directly employ or retain a Ampm Home Healthcare employee who has provided services to me in an amount no less than thirty five percent (35%) of the employee's annual compensation unless otherwise agreed in writing. I certify that I have worked the hours listed on this time sheet and that I performed the service, and that I sustained no injury during this assignment.

EMPLOYEE SIGNATURE:

Date

SUPERVISOR'S SIGNATURE:

Date

The timesheet must be filled completely, and legible and the nurse's initials in case of any changes with all signatures, then email daily to info@ampmhomehealth.com Contact:708-699-4476