

Employee Name _____
 Facility / Client Name _____
 Unit / Floor _____
 NurseCore Office _____

Weekly Instant Advance

RN LPN/LVN CNA/HHA PCA
 PT OT SLP Other: _____

Day of Week	Date	Start Time	AM	PM	Finish Time	AM	PM	Less Break	Total Approved Hours	Client Signature
Monday										
Tuesday										
Wednesday										
Thursday										
Friday										
Saturday										
Sunday										

Late Call Time / Trouble

Total Hours _____

Employee must sign here _____ **Date** _____

I certify that the hours shown above represent my total hours, are true and correct, and that they were properly verified by the client or an authorized representative. I understand that falsification of this document is against Company policy and is grounds for immediate dismissal.

Must be received by 11:00 am Monday for Weekly Pay or 11:00 am weekdays for Instant Advance.

Client: My signature certifies that the hours shown above are correct and that the employee performed satisfactorily.

Payment and Recruitment Terms and Conditions are defined in the Staffing Agreement.

TOP COPY – Branch Office (scan copy to Home Office)

Yellow – Invoice

Pink – Facility/Client

Gold – Employee

For Accounting Use Only