DNA
Dedicated Nursing Associates, Inc.

Fax: 855.726.9560
Email: ohiotimecards@dedicatednurses.com

Employee Name:_____ **Classification:** □ **RN** □ **LPN** □**STNA**

Hospice Provider:_____

DATE	TIME SHIFT START	TIME SHIFT END	LUNCH Must take lunch unless you have prior authorization	TOTAL HOURS	CRISIS CARE/CARE PARTNERS/ COMING HOME (Hospice Only)	*PATIENT NUMBER (Hospice Only)	MILES (If applicable; Please refer to mileage reimb. policy)	**EMPLOYEE SIGNATURE	***AUTHORIZED SIGNATURE(signature certifies that the hours shown are correct)
1)									
2)									
3)									
4)									
5)									
6)									
7)									
8)									
9)									
			TOTAL HRS			TOTAL MILES			

* You must enter the patient number for all cases ** Employee certifies that the hours shown above represent total hours worked for each assignment and that they were properly verified by an authorized agent. Employee also certifies that he/she was not injured on the above shifts nor did the employee receive any damages while he/she was working the above shifts. *** Authorized Agent Signature: Signature must be obtained in order to verify hours worked and to receive compensation for hours.

DNA must receive your time card for the week no later than every Monday at 11:00am in order to be processed on the upcoming payroll.