



Fax: 412.206.0591

Email: [pittsburghtimecards@dedicatednurses.com](mailto:pittsburghtimecards@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)									
			<b>TOTAL HRS</b>				<b>TOTAL MILES</b>		

\* 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.**