



**CHESAPEAKE**  
MEDICAL STAFFING

**FAX (410) 321-4980**

Time slip must be faxed in by Monday morning for weekly payroll

Hospital (Client): \_\_\_\_\_

CMS Associate Name: \_\_\_\_\_ RN / Rad. / CNA / RCP

CMS Associate Signature: \_\_\_\_\_

Shift Start Date MM/DD/YY	Shift Worked	Start Time	Finish Time	Reg. Hours	OT Hours	Authorized Hospital/Client Signature	Unit or Floor
	D E N						

\*\*\*30 minute break will be deducted from each shift greater than six hours.

Nursing Supervisor / Dept. Manager approval (printed name and initials) is required for all hours worked in excess of scheduled shift.

Print Supervisor Name: \_\_\_\_\_

Supervisor Initials: \_\_\_\_\_

Use this section to give a brief explanation for any excess time worked:

2401 York Rd., Timonium, MD 21093 • Phone (410) 321-4267



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Associate Name \_\_\_\_\_ **RN / Rad. / RCP / CNA**

Associate Signature \_\_\_\_\_

Hospital / Client \_\_\_\_\_

Day	Date	Shift	Start Time	Finish Time	Reg. Hours	OT Hours	Authorized Hospital/Client Signature	Unit/Specialty
SUN		D E N						
MON		D E N						
TUE		D E N						
WED		D E N						
THU		D E N						
FRI		D E N						
SAT		D E N						
<b>TOTAL HOURS</b>								