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						
				TOTAL HOURS				