



Fax to: (703)313-2251

If the 703 fax number does not transmit, please send an image to payroll@flexrn.com..

Employee Name:					Facility Name:		Dept:
	Date	Time In	Time Out	Break length time	Total Hours, excluding breaks	Reason for early start, short or skipped break, and/or late stop	Facility signature (Authorized signee as designated by facility)
Sunday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Monday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Tuesday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Wednesday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Thursday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Friday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
Saturday	/	<input type="checkbox"/> A <input type="checkbox"/> P	<input type="checkbox"/> A <input type="checkbox"/> P	min			
FlexRN Employee signature:				Weekly Total:	Any Overtime hours:	Facility Overtime Approval:	

*Nurse is Contracted for Guaranteed 48 hours a week and is approved for billing 48 hours.

(Supervisor Initials)