Silver Mountain Home Health care LLC. 1607 Chicago Ave MN 55404 -612-226-5375 fax 651-204-9193

NIGHT SUPERVISION TIME SHEET

Client Name: ______________________________________ **Employee Name:** _______________________________________ **File#** _______________

For the week of Thursday _____________________________ **Thru Wednesday:** ____

Thursday	Friday	Saturday	Sunday	Monday	Tuesday	Wednesday
Date: 06/01/2023	**Date:** 06/02/2023	**Date:** 06/03/2023	**Date:** 06/04/2023	**Date:** 06/05/2023	**Date:** 06/06/2023	**Date:** 06/07/2023
Time In:	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**	**Time In:**
Time Out:	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**	**Time Out:**
Please indicate the program in which you worked for this day and specify the number of hours for all that apply: ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other	*Please indicate the program in which you worked for this day and specify the number of hours for all that apply:* ______ Night Supervision ________ Other
Total Hours:	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**	**Total Hours:**
Client/Responsible Party and Staff MUST review the complete time sheet for accuracy before signing. Your signature verifies the time and services entered above are accurate and that the client was not admitted to another facility during the times provided (i.e. hospital, ICF-MR or Respite facility).						**Total Hours for the Week:**
EMPLOYEE SIGNATURE:						**Date Signed:**
CLIENT/RESPONSIBLE PARTY SIGNATURE (Please authorize all hours before signing here):						**Date Signed:**

NOTE: ALL TIMESHEETS MUST BE RECEIVED EVERY MONDAY BY 10:00 AM FOLLOWING THE WEEK WORKED. PLEASE CALL AFTER YOU SEND YOUR TIMESHEETS TO MAKE SURE THEY WERE RECEIVED.