



301 Sheyenne St
 West Fargo, ND 58078
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AGENCY EMPLOYEE TIMESHEET

Name of Employee: _____

Department: _____

Name of Healthcare Facility: _____

Period Ending: _____

Payroll: Direct Dep Mail Pick up

| DATE: | | | | | | | | | | | | | | TOTAL |
|-------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|-------|
| HOURS WORKED: | | | | | | | | | | | | | | |
| REGULAR HOURS | | | | | | | | | | | | | | |
| CALL BACK HOURS | | | | | | | | | | | | | | |
| CALL BACK HOLIDAY | | | | | | | | | | | | | | |
| OTHER PAID HOURS: | | | | | | | | | | | | | | |
| ON-CALL HOURS | | | | | | | | | | | | | | |
| WEEKEND/ HOLIDAY ON-CALL HRS | | | | | | | | | | | | | | |
| ADJUSTMENTS | | | | | | | | | | | | | | |

Employee Signature: _____

Supervisor Signature: _____