

<b>Employee Name:</b>	<b>Pay Period:</b> _____ to _____
<i>Caring Touch Nursing, Inc.</i>	<b>Office Use Only:</b>
Office: (989) 275-8000	
305 N. Fifth St.	
Fax: (989) 275-1522	
Roscommon, MI. 48653	

WEEK 1	DATE	IN	OUT	IN	OUT	TOTAL	Mileage	Facility Name/PTO/Eval./ Meetings/Inservice/Orientation/Field Orientation/Office/Other
SUN								
MON								
TUE								
WED								
THU								
FRI								
SAT								

**TOTALS - Office Use Only:**

WEEK 2	DATE	IN	OUT	IN	OUT	TOTAL	Mileage	Facility Name/PTO/Eval./ Meetings/Inservice/Orientation/Field Orientation/Office/Other
SUN								
MON								
TUE								
WED								
THU								
FRI								
SAT								

**TOTALS - Office Use Only:**

Employee Signature:	<b>Hours Worked:</b>		
	<b>PTO hrs:</b>		
	<b>Overtime hrs:</b>		
	<b>TOTAL HOURS:</b>		