



RELIABLE
HEALTH CARE SERVICES

of Southern Nevada, Inc.
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FACILITY NAME: DINI-TOWNSEND PSYCHIATRIC HOSPITAL
PROVIDER NAME: _____ ID#: _____
(PRINT)
CLASSIFICATION: RN LPN CNA OTHER _____

DATE	UNIT	TIME IN	MEALS		TIME OUT	TOTAL HOURS	OT APPROVAL	SIGNATURE OF SUPERVISOR/DATE
			OUT	IN				

_____ TOTAL HOURS FOR WEEK ENDING _____

PROVIDER SIGNATURE/DATE _____

TIME SHEETS ARE DUE EACH MONDAY BY 1PM FOR THE PRIOR SERVICE WEEK