RELIABLE
HEALTH CARE SERVICES
of Southern Nevada, Inc.
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Las Vegas, NV 89147
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FACILITY NAME: RAWSON-NEAL 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