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Client Name _____

Employee Name _____

Classification RN _____ LPN _____ CNA _____

Day of the Week _____ Date Worked _____

Start time ____:____ Finish Time ____:____

Meal Break: Y / N If No Meal Break- Facility Signature: _____

Client Signature and Title _____

Print Name and Title _____

Date _____

I certify the total hours worked and agree to the term and conditions as stated on
the back of employee copy. I also certified that I was not injured on the above shift.

Employee signature _____

Pay slip must be returned to HSE Staffing Agency within 7 days.
