



Toll Free: 866.547.5812
 Phone: 440.918.4570
 Fax: 440.975.1444

I certify that I have verified the total hours as indicated to be correct, and agree to the terms as stated in the contract. I authorize Alego Health to bill my organization for the same.

Employee Name:					Week Ending Date (Sat):		
Facility Name:					Department Location:		
Day	Date	Time Started	Time Finished	Less Meal Time	Regular Hours	Overtime Hours	Authorized Supervisor Initials
Sun							
Mon							
Tues							
Wed							
Thurs							
Fri							
Sat							
				Total Hours:			

Authorized Supervisor Signature

I hereby certify that this time ticket is true.

Employee Signature



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