

COOMBS COMPASSIONATE HOME CARE INC ®™

Box 1680, 109-111 Main Road, Bay Roberts, NL A0A 1G0 PH: 709-589-2191

PAY PERIOD: February 9-22, 2025

ACCESS WORKER: _____

Family Name: (LAST) _____ **(FIRST)** _____

Child/ren's Name(s): _____

Address: _____

Reports need to be handed in EVERY Monday.

Signed time sheets are due no later than 10AM Monday after period end date. **Please use BLACK INK!**

| Week #1 | | ACTUAL VISIT TIME Please circle "am" or "pm" | TRAVEL TIME (# OF HRS.) | REPORTS COMPLETED please circle Yes or No and note number of reports |
|---------------------------|-----------|---|----------------------------|--|
| 09 | SUNDAY | Time of visit: am/pm am/pm | | YES / NO |
| 10 | MONDAY | Time of visit: am/pm am/pm | | YES / NO |
| 11 | TUESDAY | Time of visit: am/pm am/pm | | YES / NO |
| 12 | WEDNESDAY | Time of visit: am/pm am/pm | | YES / NO |
| 13 | THURSDAY | Time of visit: am/pm am/pm | | YES / NO |
| 14 | FRIDAY | Time of visit: am/pm am/pm | | YES / NO |
| 15 | SATURDAY | Time of visit: am/pm am/pm | | YES / NO |
| WK #1 TOTAL HRS: _____ | | TOTAL of Visit Hours: _____ | TOTAL of Travel: _____ | TOTAL of REPORTS: _____ |

| Week #2 | | ACTUAL VISIT TIME Please circle "am" or "pm" | TRAVEL TIME (# OF HRS.) | REPORTS COMPLETED please circle Yes or No and note number of reports |
|---------------------------|-----------|---|----------------------------|--|
| 16 | SUNDAY | Time of visit: am/pm am/pm | | YES / NO |
| 17 | MONDAY | Time of visit: am/pm am/pm | | YES / NO |
| 18 | TUESDAY | Time of visit: am/pm am/pm | | YES / NO |
| 19 | WEDNESDAY | Time of visit: am/pm am/pm | | YES / NO |
| 20 | THURSDAY | Time of visit: am/pm am/pm | | YES / NO |
| 21 | FRIDAY | Time of visit: am/pm am/pm | | YES / NO |
| 22 | SATURDAY | Time of visit: am/pm am/pm | | YES / NO |
| WK #1 TOTAL HRS: _____ | | TOTAL of Visit Hours: _____ | TOTAL of Travel: _____ | TOTAL of REPORTS: _____ |

Cell phones ARE required for emergencies only BUT Laptops or Tablets are NOT permitted at any time.

Employee's Signature: _____

Agency Signature: _____

Please Drop off or forward time sheets to : FAX: 594-2062 or E-mail: SAdept@coombshomecare.com

FOR OFFICE USE ONLY. PLEASE LEAVE BLANK.

TOTAL HOURS OF ACTUAL VISITS: _____ TOTAL HOURS OF TRAVEL (IF APPLICABLE): _____
 TOTAL TIME OF REPORT WRITING: _____ TOTAL # OF HRS. TO BE INVOICED: _____
 SEE CHEQUE/DD#: _____