Telephone: (480) 558-3600 Fax: (480) 558-1806

YOU MAY FAX COPIES TO:
(480) 558-1806
If you fax copies, mail originals

MAIL ORIGINALS TO:

PO BOX 1865
Gilbert, AZ 85299-1865

PAID SICK TIME TIMESHEET

Employee Name: _____ Date Range (include year): _____

Clients Name Scheduled to Work With: _____

Date:	Start Time	End Time	Total Units*	Parent/Guardian Initials	Notes (if 3 or more days doctor note is required):
	am / pm	am / pm			
	am / pm	am / pm			
	am / pm	am / pm			
	am / pm	am / pm			
	am / pm	am / pm			
	am / pm	am / pm			
	am / pm	am / pm			

*Total Units Billed: (1) Unit = 60 minutes. Units are billed in ¼ hour and written as 15 min.=.25 30 min.=.50 45 min.=.75 60 min.=1.0

By signing this timesheet, both the employee and parent/guardian/client certify that the time entries are true and accurate accounts of the services/hours that were scheduled and were not worked due to the guidelines set forth in the Affinity Family Care sick time policy. It is agreed by both the employee and parent/legal guardian/client that the employee was scheduled during the above hours and was absent from a scheduled shift. The employee only agrees that the above referenced absence is taken pursuant to Arizona's paid sick time laws and Affinity Family Care's paid sick time policy. The time submitted will be verified by Affinity Family Care and no employee will be paid for unscheduled time, time that was worked and submitted on another timesheet or time that was not accrued or available to the employee. By signing below, the employee agrees to all of the above and that they meet the requirements of Affinity Family Care's paid sick time policy. By signing below the parent/guardian/client ONLY AGREES that the employee was scheduled to work and absence reported was for sick time. Sick time hours are NOT deducted from client authorization allotments.

Employee Signature (Sign/Print: _____ Date (include year): _____

Parent/Guardian/Client Signature (Sign/Print: _____ Date (include year): _____