CONSUMER / CLIENT NAME ____**CONSUMER NAME HERE**_____ **TriMED HEALTHCARE, LLC**

FAX COMPLETED TIME SHEETS TO: 215-543-3210

Employees Check-In/Out Tel # 267-753-6994 **AIDE ACTIVITY RECORD**

PRINT EMPLOYEE NAME_____**EMPLOYEE NAME HERE**

WEEK START DATE (SATURDAY)	
WEEK END DATE (FRIDAY)	

CLASSIFICATION DCW PCA HHA CNA' Other_____

TIME SHEET

DAY	DATE	START TIME	FINISH TIME	BREAK	TOTAL TIME LESS BREAK	AUTHORIZED CONSUMER SIGNATURE
SAT						*Consumer Signature*
SUN						*Consumer Signature*
MON						*Consumer Signature*
TUE						*Consumer Signature*
WED						*Consumer Signature*
THU						*Consumer Signature*
FRI						*Consumer Signature*
		TOTAL	HOURS			

CONSUMER NOTE: By your signature, you certify that hours shown are correct, work was completed satisfactorily, and you agree to the terms listed below. **It is understood that overtime at 11/2 times will be billed for over 40 hours a week unless bound by waiver conditions. Employees must CHECK-IN and CHECK-OUT daily at 267-753-6994**

EMPLOYEE NOTE: By your signature, you certify that the hours recorded for the above dates are true and accurate and are properly verified by the client. A reminder that any overtime must receive prior written approval from the Supervisor. **Holidays are paid at a flat rate. Employees Time Sheets are due every Saturday at Noon. Mail Original Time Sheets to the Corporate Head Office. Employees submitting Late timesheets will be paid the following pay period.**

Employee Signature _____/_____/_____

Employee Signature **Date**

CONDITIONS

CONSUMER Agrees to terms of NET UPON RECEIPT, and understands that unpaid amounts will be considered in default after 15 days, after which a default charge will be imposed at 11/2 % per month on unpaid balances (Annual rate of 18%) or the legal interest, whichever is lower. Consumer agrees to pay the default together with a reasonable attorney's fee for the cost of collection.

CONSUMER recognizes the rights of TriMED Healthcare, LLC as the employer and agrees not to employ the person named herein for a period of 180 days following termination of this assignment unless and assessment fee has been paid. The fee is $3000 for individuals. And 25% the projected annual wage for facilities. Do not pay the employee directly. No credit can be assured against a current invoice. Employee BONDING claims are only assured if claims are made in writing and to the local police within 14days after notice of loss.

Directions: This is a legal document. Carefully check the assignment/care plan. Initial activities completed. Clinical observations should also be called to the service coordinator or the nursing supervisor.

Place a check.√ under date of care activity actually performed.

	DATE							
	DAY	SAT	SUN	MON	TUE	WED	THU	FRI
	ACTIVITY							
BATHING	BED BATH	√	√	√	√	√	√	√
	TUB / SHOWER	√	√	√	√	√	√	√
	PARTIAL BATH	√	√	√	√	√	√	√
PERSONAL CARE	MOUTHCARE	√	√	√	√	√	√	√
	DENTURES	√	√	√	√	√	√	√
	HAIR CARE	√	√	√	√	√	√	√
	SHAMPOO	√	√	√	√	√	√	√
	EYE CARE	√	√	√	√	√	√	√
	CHANGE CLOTHES	√	√	√	√	√	√	√
	SHAVE	√	√	√	√	√	√	√
	SKIN CARE	√	√	√	√	√	√	√
	FOOT CARE	√	√	√	√	√	√	√
	TOILETING	√	√	√	√	√	√	√
	BOWEL MOVEMENT	√	√	√	√	√	√	√
	INCONTINENCE CARE	√	√	√	√	√	√	√
	CATHERTER Drain	√	√	√	√	√	√	√
AMBULATION	AMBULATE	√	√	√	√	√	√	√
	TURN & POSITION	√	√	√	√	√	√	√
	BED BOUND/ SIDE RAILS	√	√	√	√	√	√	√
	TRANSFER – CHAIR-	√	√	√	√	√	√	√
	TRANSFER -COMMODE	√	√	√	√	√	√	√
EXERCISES	ROM / EXERCISE	√	√	√	√	√	√	√
	WALK	√	√	√	√	√	√	√
MEAL PRERATION	GROCERY SHOP	√	√	√	√	√	√	√
	PREPARE MEAL /	√	√	√	√	√	√	√
	FEED/ASSIST EATING	√	√	√	√	√	√	√
	DIET INSTRUCTIONS	√	√	√	√	√	√	√
	APPETITE (DESCRIBE)	G	G	*F*	*Poor*	G	F	Poor
	FORCE FOODS/FLUIDS	√	√	√	√	√	√	√
	ENCOURAGE FLUIDS	√	√	√	√	√	√	√
	RECORD INTAKE / OUTPUT	√	√	√	√	√	√	√
HOUSE KEEPING	LAUNDRY/LINEN	√	√	√	√	√	√	√
	CLEAN BATHROOM, RM	√	√	√	√	√	√	√
	CLEAN STRIGHTEN RM	√	√	√	√	√	√	√
	CLEAN EQMT, KITCHEN	√	√	√	√	√	√	√
OTHER	MEDICATION REMINDER							
	SOCIALIZATION							

PROGRESS NOTES	SATURDAY	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
RECORD Daily Progress Notes Here e.g below →	Enter progress comment here	Enter progress comment here	Enter progress comment here	Enter progress comment here	Enter progress comment here	Enter progress comment here	Enter progress comment here

Calm Stable *Hospitalized* *Good Appetite* *Poor Appetite* *Agitated* *Regular B/M* Anxious *Sleeps well* Sleeps Little *Happy*