

Employee Time Sheet & Flow Sheet

EMPLOYEE & CLIENT INFORMATION

Employee Name _____

Client Name _____

PERSONAL CARE TIME

Time periods for each day run from 12:00 AM – 12:00 AM. If you work an overnight shift, make sure to divide your time between the two days.

YEAR: 2020		SUN		MON		TUES		WED		THUR		FRI		SAT	
Date (MM/DD)		/		/		/		/		/		/		/	
Write time and circle either AM or PM	Time Start	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
	Time End	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
Shift Total Time															
Daily Total Time															

PERSONAL CARES

Please write how many times each care was performed during each time period.

Dress/Undress															
Bathing per cp															
Hair/Shampoo/Comb															
Oral Hygiene															
Preventative Skin Care															
Nail Care															
Ambulation															
Transfer per cp															
R.O.M./Simple Exercise															
Toileting															
Incontinent Care															
Catheter Care															
Bowel Routines															
Trach/Suction															
Trach Care/G-Tube Care															
Vent															
Nebulizer															
Braces/Splints															
Complex Positioning															
Medication Assist															
Eating Assist/G-Tube															
Clean/Maintain Equip															
Lt Housekeeping per cp															
Safety Precautions															

TOTAL WEEKLY HOURS

REQUIRED SIGNATURES

We, the Client & Employee, verify this record is accurate & complete:

Employee Signature & Date

Client Signature & Date

OFFICE USE ONLY

Date Received:

Date Paid:

KPI, Inc. RN Supervisor Signature & Date