(Print) Client Name: _____

(Print) Caregiver Name:_____

Always Report!

↓2nd shift▸▸: only if you provided service for a patient more times in one day.

	Date	Time In	Time Out	Total	Client Signature
SAT					X
	2nd shift▸▸				
SUN					X
	2nd shift▸▸				
MON					X
	2nd shift▸▸				
TUES					X
	2nd shift▸▸				
WED					X
	2nd shift▸▸				
THUR					X
	2nd shift▸▸				
FRI					X
	2nd shift▸▸				
		Total week hours			Client must sign daily

Premier Care Nurses of America
2799 NW Boca Raton Blvd, Suite 204
Boca Raton, Florida 33431
Tel: 561-353-9200 Fax: 561-353-9201

Caregiver fax line only: 561-208-1254
Always report!

HHA, CNA, LPN, RN, CARE MANAGEMENT 24/7/365

IMPORTANT: READ BEFORE SIGNING

NOTICE TO CLIENT AND EMPLOYEE/CONTRACTOR

"I" means the client, caregiver and/or any authorized or informal representative signing this form.

1. I (Client) agree to make FULL PAYMENT immediately on receipt of invoice. I agree to pay interest on unpaid accounts over 30 days at 1.5% per month (18% per year), not to exceed highest legal rate. I agree to pay reasonable attorney fees and court costs for all collection of past due accounts (over 30 days).
2. I (Client) will be billed for 4 hours if cancellation after arrival of caregiver.
3. I (Client) will be billed time and a half for holidays.
4. I (Client) recognize the rights of Premier Care Nurses of America, Inc. as the referring agency. I agree not to interfere with the relationship between Premier Care and its employee/ contractor, and I agree not to hire the person named on this sheet for a period of (24) months following termination or interruption of this assignment. If I do, I agree to pay Premier Care Nurses of America, Inc a sum equal to 95% of the amount PCNA billed to me (client) in the last 90 days of service but not to be less than $7,500.00 for Recruitment and training costs, plus any attorney fees and costs incurred by Premier Care Nurses of America, Inc. in attempting to collect such liquidated damages.
5. I (Client) agree to not arrange schedules directly with the caregiver (this is for my own protection). I will inform the Agency directly of my desired schedule changes.

CLIENT: _____
Print Signature Date

HHA/CNA/RN/LPN:_____
Print Signature Date
Always report! Always report! Always report!

** **TIME SHEETS ARE DUE EVERY MONDAY BY 12 (PM) NOON** **

HHA, CNA, LPN, RN, CARE MANAGEMENT 24/7/365

PREMIER CARE NURSES OF AMERICA
CNA/HHA HOME HEALTH CARE REPORT

Client Name: _____ Week: From: ___/___/___ To: ___/___/___

	SAT	SUN	MON	TUES	WED	THUR	FRI
Date	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___
Time In (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
IF YOU WORK TWO SHIFTS A DAY FOR *ONE* PATIENT PUT *SECOND SHIFT ONLY BELOW*							
Time In (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Time Out (please circle AM/PM)	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM

PLEASE CHECK (✓) ANY ASSISTANCE YOU GAVE TO PATIENT

PERSONAL CARE	**SAT**	**SUN**	**MON**	**TUES**	**WED**	**THRUS**	**FRI**
SHOWER							
TUB BATH							
BED BATH							
SKIN CARE							
SHAMPOO							
SHAVE CLIENT							
MOUTH CARE							
ASSIST TO DRESS							
EATING							
SET UP MEAL							
FEED PATIENT							
TOILETING							
ASSIST TO TOILET							
BED PAN/URINAL							
TRANSFER TO COMMODE							
DIAPER							
FOLEY/CATHETER/COLOSTOMY							
RECORD BOWEL MOVEMENT							
ACTIVITY							
ASSIST TO WALK							
ASSIST WITH WALKER/CANE							
ASSIST WITH WHEELCHAIR							
BEDREST							
LIFT (DEVICE)							
RANGE OF MOTION							
REPOSITION							
HOME MANAGEMENT							
REMIND TO TAKE MEDS							
CLEAN BATHROOM							
CLEAN BEDROOM/HOUSE							
LAUNDRY							
GROCERY SHOP							
MAINTAIN SAFETY							
OFFICE USE ONLY							
FIRST SHIFT							
SECOND SHIFT							
TOTAL HOURS							

Client Signature: X_____ Caregiver Signature: X_____

I certify the hours and duties indicated above are correct

*CARE GIVER, PLEASE CALL NURSING SUPERVISOR WITH ANY CHANGES IN THE PATIENT'S CONDITION OR MEDICATION(S

FILL OUT DAILY AND FAX WITH TIME SHEET

Saturday:

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday: