PREMIERE Care NURSES OF AMERICA

(Print) Client Name: ____________________

(Print) Caregiver Name: ____________________

Always Report!

χ2nd shift>>: only if you provided service for a patient more times in one day.

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

Premier Care Nurses of America
5350 W Hillsboro Boulevard Suite 202,
Coconut Creek, Florida 33073
Tel: 954-531-6121

Caregiver fax line only: 954-482-0549
Always report!

HHA, CNA, LPN, RN, CARE MANAGEMENT 24/7/36

IMPORTANT: READ BEFORE SIGNING
NOTICE TO CLIENT AND EMPLOYEE/CONTRAC

"I" means the client, caregiver and/or any authorized or informal representative signi

1. I (Client) agree to make FULL PAYMENT immediately on receipt of invc pay interest on unpaid accounts over 30 days at 1.5% per month (18% per exceed highest legal rate. I agree to pay reasonable attorney fees and court 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 t agency. I agree not to interfere with the relationship between Premier Care employee/ contractor, and I agree not to hire the person named on this shee of (24) months following termination or interruption of this assignment. I to pay Premier Care Nurses of America, Inc a sum equal to 95% of the am billed to me (client) in the last 90 days of service but not to be less than $7 Recruitment and training costs, plus any attorney fees and costs incurred b 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 protection). I will inform the Agency directly of my desired schedule chan

CLIENT: ____________________
Print Signature Date

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

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

HHA, CNA, LPN, RN, CARE MANAGEMENT 24/7/3

PREMIER CARE NURSES OF AMERICA
RN/LPN HOME HEALTH CARE REPORT

Client Name: ______________________ Week: From: __/__/__ To: __/__/__

	SUN	MON	TUES	WED	THUR	FRI	SAT
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	SUN	MON	TUES	WED	THURS	FRI	SAT
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

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday: