DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance
F-62024 (Rev. 07/08)

STATE OF WISCONSIN

DAY SHIFT

REPORT OF HOURS WORKED – NURSE AIDE / DAY

Instructions for this form are available on form F-62022A.

Name - Facility	City	License Number

Schedule Dates		Time Allowed for Meal Break	Meal Break *(Check one.)*
FROM	TO		☐ Paid Time ☐ Unpaid Time

NURSE AIDE	SUN	MON	TUE	WED	THUR	FRI	SAT	SUN	MON	TUE	WED	THUR	FRI	SAT
SUB-TOTAL														
GRAND TOTAL														