**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Quality Assurance

F-62440 (Rev. 02/09)

#### DAY SHIFT

##### REPORT OF HOURS WORKED – OTHER DIRECT CARE NURSE AIDE / DAY

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

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| Name - Facility | | | | | | | | City | | | | | | License Number | | | | |
| Schedule Dates | | | | | | | | Time Allowed for Meal Break | | | | Meal Break *(Check one.)* Paid Time  Unpaid Time | | | | | | |
| FROM | TO | | | | | | |
| OTHER DIRECT CARE NURSE AIDE | | SUN | MON | TUE | WED | THUR | FRI | | SAT | SUN | MON | | TUE | | WED | THUR | FRI | SAT |
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| SUB-TOTAL | |  |  |  |  |  |  | |  |  |  | |  | |  |  |  |  |
| GRAND TOTAL | |  |  |  |  |  |  | |  |  |  | |  | |  |  |  |  |