

COOMBS HOME CARE INC ®™

Box 1680, 109-111 Main Road, Bay Roberts, NL A0A 1G0 PH: 709-589-2191

PAY PERIOD: Oct 4-17, 2026

ACCESS WORKER: _____

Family Name: (LAST) _____ **(FIRST)** _____

Child/ren's Name(s): _____

Address: _____

Reports need to be handed in EVERY Monday.

Signed time sheets are due no later than 10AM Monday after period end date. **Please use BLACK INK!**

Week #1		ACTUAL VISIT TIME Please circle "am" or "pm"	TRAVEL TIME (# OF HRS.)	REPORTS COMPLETED please circle Yes or No and note number of reports
4	SUNDAY	Time of visit: am/pm am/pm		YES / NO
5	MONDAY	Time of visit: am/pm am/pm		YES / NO
6	TUESDAY	Time of visit: am/pm am/pm		YES / NO
7	WEDNESDAY	Time of visit: am/pm am/pm		YES / NO
8	THURSDAY	Time of visit: am/pm am/pm		YES / NO
9	FRIDAY	Time of visit: am/pm am/pm		YES / NO
10	SATURDAY	Time of visit: am/pm am/pm		YES / NO
WK #1 TOTAL HRS: _____		TOTAL of Visit Hours: _____	TOTAL of Travel: _____	TOTAL of REPORTS: _____

Week #2		ACTUAL VISIT TIME Please circle "am" or "pm"	TRAVEL TIME (# OF HRS.)	REPORTS COMPLETED please circle Yes or No and note number of reports
11	SUNDAY	Time of visit: am/pm am/pm		YES / NO
12	MONDAY	Time of visit: am/pm am/pm		YES / NO
13	TUESDAY	Time of visit: am/pm am/pm		YES / NO
14	WEDNESDAY	Time of visit: am/pm am/pm		YES / NO
15	THURSDAY	Time of visit: am/pm am/pm		YES / NO
16	FRIDAY	Time of visit: am/pm am/pm		YES / NO
17	SATURDAY	Time of visit: am/pm am/pm		YES / NO
WK #1 TOTAL HRS: _____		TOTAL of Visit Hours: _____	TOTAL of Travel: _____	TOTAL of REPORTS: _____

Cell phones ARE required for emergencies only BUT Laptops or Tablets are NOT permitted at any time.

Employee's Signature: _____

Agency Signature: _____

Please Drop off or forward time sheets to : FAX: 594-2062 or E-mail: juanita@coombshomecare.com

FOR OFFICE USE ONLY. PLEASE LEAVE BLANK.

TOTAL HOURS OF ACTUAL VISITS: _____ TOTAL HOURS OF TRAVEL (IF APPLICABLE): _____
 TOTAL TIME OF REPORT WRITING: _____ TOTAL # OF HRS. TO BE INVOICED: _____
 SEE CHEQUE/DD#: _____