EMPLOYEE NAME:_____ FAX TO: 1-800-259-0287

DEPARTMENT:_____ SSN (last 4 digits): _____

HOSPITAL NAME:_____ Recruiter:_____

REGULAR HOURS

	Date	Start Time	End Time	Less: Lunch	Total
Sun.					
Mon.					
Tues.					
Wed.					
Thurs					
Fri.					
Sat.					
				Total hours	

Bill / Pay:

ON CALL HOURS

Call Back Hours

Date	# of Hours on Call	Time in	Time out	Time in	Time out	Total Call Back Hours

Per Diem _____ Bill / Pay

Car Allowance _____ Bill / Pay

Living Allowance _____ Bill / Pay

Housing Allowance _____ Bill / Pay

Other Allowance _____ Bill / Pay

Reimbursement _____

Cable Reimbursement _____

Phone Reimbursement _____

Housing Reimbursement _____

Other Reimbursement _____

EMPLOYEE SIGNATURE:_____ DATE:_____

SUPERVISOR SIGNATURE:_____ DATE:_____