Quality Medical Staffing

Name: ____

RN______ LPN______ CNA ______ Other __________________________

Facility: _____________________________ Unit/Floor:

____

Date_______________

Time In: _______________ Break: ____________

Time Out: ______________ Total Time: __________ (Overtime Shift: ___Yes)

Mileage: _______________

I certify that the hours shown above represent my total hours worked and that I have obtained an authorized signature from a facility/client representative. I recognize the rights of Quality Medical Staffing, LLC., as the employer and agree not to be employed by the facility individually or through an agent for a period of 90 days following the termination of this assignment without approval of Quality Medical Staffing. Failure to complete this document accurately may result in my pay being delayed.

(X) ___________________________

Employee's Signature

I agree to terms per contract agreement and recognize the rights of Quality Medical Staffing, LLC. as the employer and agree not to employ directly in any capacity the person named hereon without first providing Quality Medical Staffing, LLC. at least 90 days written notice following the termination of this assignment. I certify that the hours shown above are correct and that the employee performed satisfactorily.

(X) ___________________________

Authorized Facility Signature

White-Quality Medical Staffing   Canary- Employee   Pink-Facility

For Agency Use:

Invoice # _________ Paid On: _______ Check # _______

1-877-426-8793· Fax (505) 426-8793