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