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- Cash Card
 Direct Deposit
 Mail check
 Hold check for pick-up

Client/Facility Name: (PLEASE PRESS FIRMLY)

Employee Name: Soc. Sec. No./Payroll I.D. No.:

Circle Classification or Write in: License No.
 NP RN LPN CNA

LOCAL TRAVEL	DAY	DATE	SHIFT	CIRCLE ONE	UNIT CODE UNIT TYPE	WORKED HOURS ONLY
YES No				Med/Surg Speciality		
Time In				Time Out		

Lunch Taken (Circle One): Yes No

MANDATORY EXPLANATION OF ANY TIME WORKED BEYOND SHIFT

HOSPITAL REPRESENTATIVES:
 PLEASE AUTHORIZE BY INITIALIZING _____

I, the undersigned, certify that this is an accurate record of my working time and that it was properly verified by the client or an authorized representative. I recognize the rights of **Progressive Nursing Staffers** as the employer and agree not to be employed by the client named above for a period of 60 days following the termination of this assignment. I also certify that no injury was incurred by me during this assignment.

EMPLOYEE SIGNATURE

I certify that the above hours are correct and that the employee performed their duties satisfactorily. I understand that I do not pay the employee directly and Progressive Nursing Staffers will pay the employee. I recognize the rights of **Progressive Nursing Staffers** as the employer and agree not to employ the employee named above individually or through an agent for a period of 60 days following the termination of this assignment without approval of **Progressive Nursing Staffers** authorized representative.

Please use the back of client copy for performance evaluation as needed.

AUTHORIZED SIGNATURE

NURSES UPCOMING AVAILABILITY/COMMENTS:

White - Office Copy

Yellow - Employee

Pink - Client Copy