



Cash Card

Daily Direct Deposit

Weekly Direct Deposit

Email to: [springfieldpayroll@progressivenursing.com](mailto:springfieldpayroll@progressivenursing.com)

Fax to: 1-877-337-7695

Client/Facility Name: (PLEASE PRESS FIRMLY)						
Employee Name: (PRINTED)				Soc. Sec. No./Payroll I.D. No.:		
Circle Classification or Write in: NP      RN      LPN      CNA				License No.		
LOCAL TRAVEL	DAY	DATE	SHIFT	CIRCLE ONE	UNIT CODE UNIT TYPE	WORKED HOURS ONLY
YES No				Med/Surg Specialty		
Time In				Time Out		
Lunch Taken (Circle One):    YES            NO						
MANDATORY EXPLANATION OF ANY TIME WORKED BEYOND SHIFT						
<b><u>HOSPITAL REPRESENTATIVES:</u></b>						
PLEASE AUTHORIZE BY INITIALIZING _____						
<p>I, the undersigned, certify that this is an accurate record of my working time and it was properly verified by this client or an authorized representative. I recognize the rights of <b>Progressive Nursing Staffers</b> 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.</p>						
_____						
EMPLOYEE SIGNATURE						
<b>Hours Authorization and Performance Evaluation:</b>						
<p>I certify that the above hours are correct and that the employee performed their duties in a manner that meets your facility's job standards. If the <b>Progressive</b> employee's performance has not met your standards please complete the performance evaluation on the back of this form and fax to 1-877-337-7695. You may also contact our office directly at 888-750-1012 to speak with a manager.</p>						
<i>Please use the back of client copy for performance evaluation as needed.</i>						
_____						
AUTHORIZED SIGNATURE						
Authorized Representative Name (PRINTED):						
<b>NURSES UPCOMING AVAILABILITY/COMMENTS:</b>						

PERFORMANCE EVALUATION:

circle rating

Overall Performance:	O	E	G	F
Nursing Ability:	O	E	G	F
Cooperation:	O	E	G	F
Attitude:	O	E	G	F
Judgement:	O	E	G	F
Reliability:	O	E	G	F
Flexibility:	O	E	G	F
Productivity:	O	E	G	F

KEY:

O = Outstanding  
G = Good

E = Excellent  
F = Fair

By: \_\_\_\_\_ Date: \_\_\_\_\_

Remarks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*For a more detailed evaluation form contact  
Progressive Nursing Staffers.*