Progressive Nursing Staffers
THE Nursing OFFICE

Cash Card ❑
Daily Direct Deposit ❑
Weekly Direct Deposit ❑

Email to: springfieldpayroll@progressivenursing.com
Fax to: 1-877-337-7695

Client/Facility Name: (PLEASE PRESS FIRMLY)

Employee Name (PRINTED)

Circle Classification or Write in:
RN / LPN / CNA / Sitter / Other _____

LOCAL TRAVEL	DAY	DATE	CIRCLE ONE	UNIT CODE UNIT TYPE	WORKED HOURS ONLY
Yes No			Med/Surg Specialty		
Time In			Time Out		

MANDATORY EXPLANATION OF ANY TIME WORKED BEYOND SHIFT OR NO LUNCH TAKEN REQUIRED BELOW

Temp Initials

HOSPITAL REPRESENTATIVES:
PLEASE AUTHORIZE EXTRA TIME WORKED BY INITIALING

Client Initials

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 ***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

Hours Authorization and Performance Evaluation:
I certify that the above hours are correct and that the employee performed their duties in a manner that meets the facility's job standards. If the ***Progressive*** 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 1-888-750-1012 to speak with a manager.

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

_____
AUTHORIZED SIGNATURE

Authorized Representative Name (PRINTED):

White-Client Copy

Yellow-Temp Copy