

 <b>PRIORITY MEDICAL STAFFING</b> 8660 Fern Ave, Suite 160 Shreveport, LA 71105 TEL: (318) 865-0088 • 800-256-9426 EIN# 14-1995281 FAX: (318) 865-0436 • 888-696-5706			Name			Credentials		
			Client Facility			Unit • Floor		
			Day Sun Mon Tue Wed Thu Fri Sat			Date / /		
Scheduled Shift	Scheduled Hours	Start Time	End Time	Lunch Break	Total Hours Worked	No	Yes	Initials [Orientation Hours _____]
						<input type="checkbox"/>	<input type="checkbox"/>	Worked Lunch / No Break
						<input type="checkbox"/>	<input type="checkbox"/>	Client Approved Premium Pay
						<input type="checkbox"/>	<input type="checkbox"/>	Worked as RN Charge
						<input type="checkbox"/>	<input type="checkbox"/>	Client Approved Over-Time
In consideration for services by Priority Medical Staffing the Client agrees not to directly or indirectly hire the employee named above except with written permission of Priority Medical Staffing and agrees that such employee shall remain an employee of Priority Medical Staffing furnishing services to the Client for a period of not less than 12 weeks from the date of such permission.						<b>FOR FACILITY / HOSPITAL USE SUPERVISORS ONLY</b>		
My signature on this time sheet certifies that the information that I have listed on my time sheet is true and correct and the duly authorized representative of the Client has reviewed and signed this time sheet verifying the time sheet is correct and approved for payment.								
<input type="checkbox"/> Same Day Pay <input type="checkbox"/> Weekly Pay		<input type="checkbox"/> Direct Deposit <input type="checkbox"/> Payroll Card		<b>White Copy/PMS ~ Yellow Copy/Employee ~ Pink Copy/Client</b>				
Employee I.D. #	Employee Signature	Client Signature			VOID AFTER 60 DAYS			

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