MILLENIA
MEDICAL STAFFING

Staffing Healthcare Everywhere

Check One:
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Facility Name:____

Employee Name:____

Classification: ☐ RN ☐ LPN ☐ CNA ☐ Other:______________

Date Worked:_________________________ Area/Floor:______________

SHIFT:

Total Hours Worked:____

Time In:_________ Time Out: _________ Meal: (0 min) (30 min) (60 min)

Overtime Approved: ☐ Yes ☐ No

I certify that the hours shown above are my total hours worked and they were properly verified by the facility or its authorized representative. I also agree that I was not injured on the above shift, nor have I received any damages while I was working the above shift.

____

Employee Signature Date Signed

Facility agrees not to employ directly in any capacity the person named hereon without first providing at least ninety (90) days written notice following the termination of this assignment. I certify that the hours shown above are correct and that the employee performed satisfactory.

Eligible to Return: ☐ Yes ☐ No

____

Signature of Facility Representative Date Signed

Please fax timeslips at the end of your shift in order to have your checks ready.

White - Employer Yellow - Facility Pink - Employee

www.milleniamedical.com

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