



Please upload JPG of timesheet to: [Click here to access Workforce Portal](#)

1.888.56NURSE

EMPLOYEE NAME: LAST NAME, FIRST NAME (PLEASE PRINT)																									

Staff Signature: \_\_\_\_\_ Client/Facility Name: \_\_\_\_\_

- RN
- LPN
- CST/ORT
- OTHER: \_\_\_\_\_
- RRT
- CRT
- CNA

DATE	UNIT	TIME IN	TIME OUT	LUNCH		WORKED AS CHARGE NURSE	TOTAL HOURS WORKED	CLIENT INITIALS
				<input type="checkbox"/> No	SUP. INITIALS			

DATE	ON CALL	CALL BACK		CALL BACK		CALL BACK		ON CALL	CLIENT INITIALS
	TIME IN	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME OUT	

In consideration for services provided by Gifted Healthcare, the undersigned agrees not to hire the staff member named above directly or indirectly except with written permission from Gifted Healthcare. The Client representative's signature below acknowledges services rendered. Terms: Payable upon receipt.

CLIENT REPRESENTATIVE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Performance Evaluation (5-Truly Gifted 1-Poor)

1	2	3	4	5
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- Would Request Again
- Would Not Request Again

Time Sheet Void After Thirty (30) Days