Medical Staffing Solutions, LLC
Email: ivhtimesheets@mssmedicalstaffing.com
Fax: 765.807.3291
Phone: 765.588.0775

Employee Name:_____ **Facility:**_____ **Discipline:** _____

REGULAR HOURS								
Day	**Date**	**Unit**	**Start**	**End**	**Lunch**	**No Lunch**	**Mileage**	**Supervisor Signature**
SUN								
MON								
TUE								
WED								
THUR								
FRI								
SAT								

MSS will automatically deduct 30 minutes for lunch break, if not noted.

ON CALL HOURS						
Day	**Date**	**Unit**	**Start**	**End**	**Lunch**	**Supervisor Signature/Specific Hours**
SUN						
MON						
TUE						
WED						
THUR						
FRI						
SAT						

FACILITY: The supervisor signing is authorized to verify hours worked by Medical Staffing Solutions, LLC personnel, agrees that the time stated is correct and that the work was performed satisfactorily. Client acknowledges that payment is due as stated in the Professional Services Agreement. Facility agrees to notify Medical Staffing Solutions, LLC immediately up on the occurrence of any accident, clinical incident, ethics violation or any other issue involving Medical Staffing Solutions, LLC employee(s). Please complete the below evaluation tool to further assist us with providing quality healthcare professionals. Your comments are important to us!

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Competency Evaluation Tool – please circle one

Excellent = E Good = G Fair = F Poor = P

Technique/Skill	E	G	F	P
Use of equipment	E	G	F	P
Safety/Infection Control	E	G	F	P
Professionalism	E	G	F	P
Productivity/Efficiency	E	G	F	P
Documentation	E	G	F	P

Comments:

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EMPLOYEE: My signature below indicates that I understand MSS must be contacted immediately when contracted hours are reduced for the week. Failure to contact MSS within the week of reduced hours may result in loss of per diem reimbursements.

HOURS NOT WORKED/CANCELLED - voluntary or mandatory time off				
Date	**Hours not worked**	**Reason for cancellation:**	**Voluntary or Mandatory time off:**	**Supervisor Signature:**

Employee Signature: _____