



Medical Staffing Solutions, LLC
 Email: timesheets@mssmedicalstaffing.com
 Text or Fax: 812.720.3637
 Questions? Call us at 812.469.6877

Employee Name: _____ Facility: _____ Discipline: _____

REGULAR HOURS							
Day	Date	Unit	Start	End	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!

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:

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: _____