URGENT | Medical * STAFFING | Solutions

315 West James St. Suite 103 A | Lancaster PA 17603
Payroll Email: payroll@umssrf.com | F- 717-326-1395

PLEASE PRINT CLEARLY

CLIENT NAME:_____

EMPLOYEE NAME:_____

LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER:_____

DISCIPLINE: ☐ RN ☐LPN ☐CNA ☐OTHER:_____

DATE WORKED: _____ UNIT/FLOOR: _____

CHECK ONE: ☐SUNDAY ☐MONDAY ☐TUESDAY ☐WEDNESDAY ☐THURSDAY ☐FIRDAY ☐SATURDAY

SHIFT: TIME IN: _____ SHIFT OUT: _____

MEAL BREAK: ☐YES ☐30 MIN ☐60 MIN ☐OTHER:_____

☐NO _____ (Initials of AUTHORIZED Client representative)

COMPLETED BY FACILITY

TOTAL HOURS WORKED: ___ OVERTIME APPROVED (Check one): ☐Yes ☐No

I recognize the rights of Urgent Medical Staffing Solutions, LLC as the employer and agree not to employee directly in any capacity the person named hereon without first providing Urgent medical staffing solutions, LLC at least 180 days' written notice following the termination of this assignment. I certify that the hours shown above are correct and that the employee performed satisfactory.

_____ _____

SIGNATURE OF AUTHORIZED CLIENT REPRESENTATIVE DATE

I certify that the hours shown above represent my true total hours worked and that they were properly verified by the client or by an authorized representative. I also certify that I was not injured on the above shift. I recognize the rights of Urgent Medical Staffing Solutions, LLC as the employer and agree not to be employed by the client/facility identified above, directly or indirectly, for a period of one hundred and eighty (180) days from the termination of this assignment without approval of Urgent Medical Staffing Solutions, LLC. I will submit this time sheet within seven (7) of the date worked.

_____ _____

EMPLOYEE SIGNATURE DATE

Time sheet MUST BE RETURNED to Medical Staffing Solutions, LLC every Monday by NOON.
Time sheets can be faxed to 717-326-1395 or EMAILED to: payroll@umssrf.com.

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