medical solutions

Employee Name: _____

Hospital: _____

Instructions:

1. **Please be sure to list all in and out times, not just total hours including lunch times.**
2. **Please note any exceptions in the space marked comments(no lunch, stayed late on case, left early, sent home by hospital, etc.)**
3. **Time is calculated by actual in/out times and is not rounded unless specified by hospital protocol.**
4. **Show time worked in MILITARY TIME.**

	Day	Date	Time In	Lunch Out	Lunch In	Time Out	Total Hours	Comments
Regular Hours	Sun							
	Mon							
	Tues							
	Wed							
	Thurs							
	Fri							
	Sat							
						Total for Week:		

	Day	Date	On Call In	On Call Out	Total On Call	Call Back In	Call Back Out	Total Call Back	Call Back Reason
Call Hours	Sun								
	Mon								
	Tues								
	Wed								
	Thurs								
	Fri								
	Sat								
			Total On Call for Week:			**Total Call Back for Week:**			

******If guaranteed hours are not met, please specify reason******

Codes
H = Holiday Worked
C = Facility Closed
S = Sent Home by Facility
P = Personal Time Off/Sick
NM = No Meal Period CHG-Charge

Medical Solutions Employee Signature

_____/_____

Signature **Date**

* By signing, the employee certifies that the hours listed above are true and correct.

Authorized Client Facility Signature

_____/_____

Signature **Date**

* By signing, the client certifies that the hours listed above are true and correct, and will pay according to the hours listed above.

OFFICE USE ONLY	
	P
Regular	
Overtime	
Charge	
On Call	
Call Back	
Holiday	

*****ATTENTION TRAVELERS*****

Timesheets without supervisor signatures will not be processed. All timesheets must be faxed to Medical Solutions (Fax: 1-866-357-2102) by **Monday 3:00 pm**. If you have any questions or concerns please call 1-866-633-3548.