Employee Name | Employee Signature | Date

Hospital/Facility | Authorized Supervisor Signature* | Date

*By signing the employee certifies that the hours listed below are true and correct

*By signing the supervisor certifies that the hours listed below are true and correct

Analytics Medical Staffing

	Date	Time In	Lunch Out	Lunch In	No Lunch	Time Out	Total Hours	Campus	Unit	Reason for Call-Off (circle one)	Comments
Mon		:	:	:	Check if no lunch	:				Hospital / Personal	
Tue		:	:	:	Check if no lunch	:				Hospital / Personal	
Wed		:	:	:	Check if no lunch	:				Hospital / Personal	
Thu		:	:	:	Check if no lunch	:				Hospital / Personal	
Fri		:	:	:	Check if no lunch	:				Hospital / Personal	
Sat		:	:	:	Check if no lunch	:				Hospital / Personal	
Sun		:	:	:	Check if no lunch	:				Hospital / Personal	

Total for Week

IF GUARENTEED HOURS ARE NOT MET, PLEASE SPECIFY REASON*"**

Comments:

CALL HOURS:

ON CALL

	Date	Time In	Time Out	Total On-Call Hours
Mon		:	:	
Tue		:	:	
Wed		:	:	
Thu		:	:	
Fri		:	:	
Sat		:	:	
Sun		:	:	

Total On-Call for Week

CALL BACK

Time In	Time Out	Total Call Back	Call Back Reason
:	:		
:	:		
:	:		
:	:		
:	:		
:	:		
:	:		

Total Call Back for Week

Send Completed and Signed Timesheets to PAYROLL@ANALYTICSMEDSTAFF.COM