



# INFUSION / PER DIEM / PRN TIMECARD

Fax Completed Nursing Notes to 888-400-6220

EMPLOYEE NAME: LAST NAME, FIRST NAME (PLEASE PRINT)																												

Nurse Signature: \_\_\_\_\_ Client/Pharmacy: \_\_\_\_\_

Direct Deposit

Pay Card

Mail

Check in Metairie

Check in Mandeville

Check in Lafayette

Check in Tulsa

Check in Oklahoma City

Check in Little Rock

RN

LPN

DATE	UNIT	TIME IN	TIME OUT	TOTAL HOURS WORKED	PATIENT INITIALS

ODODMETER START	ODODMETER END	TOTAL MILES	TRAVEL TIME

In consideration for services provided by Gifted Healthcare, the undersigned agrees not to hire the staff member named above directly or indirectly except with written permission from Gifted Healthcare. The Client representative's signature below acknowledges services rendered. Terms: Payable upon receipt.

CLIENT / PATIENT REPRESENTATIVE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

Performance Evaluation (5- Truly Gifted 1-Poor)

1	2	3	4	5
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Would Request Again

Would Not Request Again

Time Sheet Void After Thirty (30) Days

White: Gifted Nurses Yellow: Client/Facility