PER DIEM / PRN TIMECARD

1.888.56NURSE • payroll@giftedhealthcare.com • Payroll Fax 800.918.3727

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

Staff Signature: _____ **Client/Facility Name:** _____

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 ☐ **RRT ☐**
LPN ☐ **CRT ☐**
CST/ORT ☐ **C.N.A ☐**
Other: _____

DATE	UNIT	TIME IN	TIME OUT	LUNCH		WORKED AS CHARGE NURSE	TOTAL HOURS WORKED	CLIENT INITIALS
				☐ No	SUP. INITIALS			

DATE	ON CALL	CALL BACK		CALL BACK		CALL BACK		ON CALL	CLIENT INITIALS
	TIME IN	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME IN	TIME OUT	TIME OUT	

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 REPRESENTATIVE SIGNATURE **DATE**

Would Request Again ☐
Would Not Request Again ☐

Time Sheet Void After Thirty (30) Days
White: Gifted Nurses Yellow: Client/Facility

Performance Evaluation (5-Truly Gifted 1-Poor)

1	2	3	4	5