GIFTED HEALTHCARE

1.888.56NURSE

LOCAL CONTRACTS - NOT TRAVEL

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

Direct Deposit ☐ **Pay Card** ☐ **RN** ☐ **LPN** ☐ **CST/ORT** ☐

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

DAY	DATE	UNIT WORKED	TIME IN	TIME OUT	LUNCH		TOTAL HOURS WORKED	WORKED AS CHARGE NURSE	ON CALL	CALL BACK		CALL BACK		ON CALL	SUPERVISOR SIGNATURE
									IN	IN	OUT	IN	OUT	OUT	
SUN					☐ No	Sup Initials		☐ Yes							
MON					☐ No	Sup Initials		☐ Yes							
TUES					☐ No	Sup Initials		☐ Yes							
WED					☐ No	Sup Initials		☐ Yes							
THURS					☐ No	Sup Initials		☐ Yes							
FRI					☐ No	Sup Initials		☐ Yes							
SAT					☐ No	Sup Initials		☐ Yes							

Please upload JPG of timesheet to: Click here to access Workforce Portal

Timesheets due Sunday by midnight

PERFORMANCE EVALUATION TO BE COMPLETED BY SUPERVISOR WEEKLY							
QUALITY OF WORK	1	2	3	4	5	5 – TRULY GIFTED 4 – VERY GOOD 3 – GOOD 2 – FAIR 1 - POOR	Please circle one number in each row which best reflects your assessment of the employee based on the scale at the left
DOCUMENTATION	1	2	3	4	5		
CLINICAL ABILITY	1	2	3	4	5		
PROFESSIONALISM/ATTITUDE	1	2	3	4	5		
ATTENDANCE/PUNCTUALITY	1	2	3	4	5		
COMMENTS							

In consideration for services provided by Gifted Healthcare, the above signed agrees not to hire the staff member named above directly or indirectly except with written permission from Gifted Healthcare. The client representative's signature above acknowledges services rendered, that the above hours are correct and the employee's performance was satisfactory.

_____ _____

CLIENT REPRESENTATIVE SIGNATURE DATE