

Facility worked: \_\_\_\_\_ Employee: \_\_\_\_\_ Discipline: \_\_\_\_\_

(RN, LPN, CNA, PT, etc.)

TIME WORKED								
Day	Date	Unit	In	Out (lunch)	In (lunch)	Out	Total Hrs.	Client Supv. Sig.
Sun								
Mon								
Tue								
Wed								
Thu								
Fri								
Sat								

1. Employees must use one time sheet per facility worked. 2. Timesheet must be turned in by 4:00 p.m. Monday to be paid Thursday. 3. Please call MSS office to verify receipt. 4. MUST HAVE FACILITY SIGNATURE TO BE PAID. 5. MSS will prosecute for any misrepresentation of time worked.

EMPLOYEE SIGNATURE \_\_\_\_\_

WHITE COPY: FAX OR EMAIL TO MSS      YELLOW COPY: FACILITY

Competency Evaluation Tool (circle one)	Excellent	Good	Fair	Poor
1. Techniques/Procedures/Skills	E	G	F	P
2. Use of technology/equipment	E	G	F	P
3. Compliance w/ safety & infection control standards	E	G	F	P
4. Professionalism (dress, cooperation, affect)	E	G	F	P
5. Produce timely & efficient work	E	G	F	P
6. Documentation standards	E	G	F	P
<b>Comments:</b>				

Agreement: The individual signing is authorized to verify hours worked by Medical Staffing Solutions, LLC personnel, agrees that the time stated is correct and that the work was performed satisfactorily. Client acknowledges that paymnet is due as stated in the Professional Services Agreement. Facility agrees to notify Medical Staffing Solutions, LLC immediately upon the occurrence of any accident, clinical incident, ethics violation or any other issue involving Medical Staffing Solutions, LLC employee(s).

CLIENT SUPV. SIGNATURE \_\_\_\_\_

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