Provider Timesheet

locumschoice

Important Information:
To ensure timely payment, please complete and return this time sheet by **Monday at 5:00pm EST.**
Time sheets can be filled out electronically & emailed directly to your Recruiter.

Provider Name: _____ Date: _____

Facility Name: _____

City/State: _____

	Date	Hospital or Clinic?	Shift Start Time	Shift End Time	Total Shift Hours	On-Call?	Call Start Time	Call End Time	Call Back Hours
Mon.		H C				Yes			
Tues.		H C				Yes			
Wed.		H C				Yes			
Thurs.		H C				Yes			
Fri.		H C				Yes			
Sat.		H C				Yes			
Sun.		H C				Yes			

TOTAL SHIFT HOURS: 0.00 **TOTAL CALL BACK HOURS:** 0.00

Notes:

Provider Signature: _____ **Date:** _____

The Provider's signature verifies that all the hours on this time sheet are true, accurate and associated with the designated client.

Client Signature: _____ **Date:** _____

By signing this time sheet the client representative certifies that he/she is authorized by the client to approve this time sheet. In addition, the client's signature verifies that the provider has accurately completed this time sheet and charts and worked the hours reported above.