TRiNiTY
healthcare staffing group

Check Delivery

Hold Mail

time@trinityhsg.com
843.656.0545
(FAX) 866.213.5933
(FAX) 843.629.9030
P O Box 5955
Florence, SC 29502

Employee Name _____

Classification _____
(RN, LPN, etc.)

Facility Name _____

Regular Hours

DAY	DATE	AREA WORKED	CHARGE	TIME STARTED	TIME FINISHED	LUNCH	TOTAL HOURS	SUPERVISOR INITIALS	CANCELED SHIFT BY:
SUN				AM PM	AM PM	MIN			
MON				AM PM	AM PM	MIN			
TUES				AM PM	AM PM	MIN			
WED				AM PM	AM PM	MIN			
THUR				AM PM	AM PM	MIN			
FRI				AM PM	AM PM	MIN			
SAT				AM PM	AM PM	MIN			

On Call Hours

DAY	DATE	AREA WORKED	CHARGE	TIME STARTED	TIME FINISHED	LUNCH	TOTAL HOURS	CALL BACK (Specific Hours)
SUN				AM PM	AM PM	MIN		
MON				AM PM	AM PM	MIN		
TUES				AM PM	AM PM	MIN		
WED				AM PM	AM PM	MIN		
THUR				AM PM	AM PM	MIN		
FRI				AM PM	AM PM	MIN		
SAT				AM PM	AM PM	MIN		

O **Check this box ONLY if you traveled over fifty miles ONE WAY to work any of the above shifts for this facility.**

I certify that the hours stated above are true and accurate and that no injuries were sustained during any of these shifts.
Employee Signature _____

I agree to terms of Trinity Healthcare Staffing Group, Inc. as stated per Billing Policy. I certify that all hours shown above are correct and that the employee performed satisfactorily.
Signature of Authorized Client ONLY _____

The rates that are billed are inclusive of all cost associated with the specific travelers on assignment at your facility(s) such as wages, payroll taxes, insurance, meals and lodging costs. All invoices will indicate the amount of Meals and Lodging costs paid to Healthcare Professional(s) on behalf of Client. Adequate records and/or other means will be maintained to satisfy substantiation requirements of IRS.

INTERNAL USE ONLY Pay_____Bill _____