ConTemporary Nursing Solutions

Payroll Toll Free Phone: 888-767-4968
Payroll Local Phone: 703-354-5151
Payroll Local Fax: 703-354-9727
Payroll TEXT: 434-841-9807

Mail Check ☐ **Direct Deposit** ☐ **EZPay** ☐

Hospital / Facility ________________________________

Clinician's Name _________________________________

I certify that the hours shown below represent my true hours worked and that no injury occurred during the shift. I authorize CTS to withhold all required taxes, voluntary benefit payments, authorized garnishments or deductions. I understand and agree to submit this timesheet within 15 days of date worked.

CTS Clinician's Signature:____________________

UNIT:______________________________________

_____**Specialty**

_____**Med/Surg**

_____**On Call**

_____**Charge**

Su M Tu W Th Fr Sa

Date Shift Started

_______/_______/______

Time In: ____________ **AM / PM**

Time Out: __________ **AM / PM**

"No Break" Initials of supervisor ☐

Break : _____________________

Total Hours: _______________

Floating:
Hospital understands this specialty clinician has agreed to float to non-specialty unit. The hospital will be billed specialty rates and the clinician will be paid specialty rates.

Supervisor Initials: _______________

I am an authorized representative of the client facility and the information above is accurate and all services provided were satisfactory. This client facility recognizes the rights of ConTemporary Nursing Solutions, Inc. as the employer and agrees not to hire the employee identified above for a period of 180 days from the termination of this assignment without approval of CTS.

____ **Date:** ___________
Signature of Authorized Representative of Facility

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