INFUSION / PER DIEM / PRN TIMECARD

Fax Completed Nursing Notes to 888-400-6220

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

Nurse Signature: _____ **Client/Pharmacy:** _____

Direct Deposit☐ **Pay Card ☐** **Mail ☐**

Check in Metairie ☐ **Check in Covington ☐** **Check in Lafayette ☐** **Check in Tulsa ☐** **Check in Oklahoma City ☐** **Check in Little Rock ☐**

RN ☐

LPN ☐

DATE	UNIT	TIME IN	TIME OUT	TOTAL HOURS WORKED	PATIENT INITIALS

ODODMETER START	ODODMETER END	TOTAL MILES	TRAVEL TIME

In consideration for services provided by Gifted Healthcare, the undersigned agrees not to hire the staff member named above directly or indirectly except with written permission from Gifted Healthcare. The Client representative's signature below acknowledges services rendered. Terms: Payable upon receipt.

_____ _____

CLIENT / PATIENT REPRESENTATIVE SIGNATURE **DATE**

Would Request Again ☐

Would Not Request Again ☐

Time Sheet Void After Thirty (30) Days

White: Gifted Nurses **Yellow: Client/Facility**

Performance Evaluation (5-Truly Gifted 1-Poor)

1	2	3	4	5