ACUTE
NURSING SOLUTIONS

NAME and TITLE:_____

HOSPITAL:_____

DEPARTMENT and SHIFT ASSIGNED:_____

TODAY'S DATE:_____

TIME IN:_____

TIME OUT:_____

LUNCH: ☐ YES ☐ NO _____ (If **NO**, must be initialed by **Charge RN**)

TOTAL WORK TIME:_____

CHARGE NURSE SIGNATURE:_____

PLEASE OBSERVE THE FOLLOWING GUIDELINES:

1. Please take this form with you to the department you are assigned.
2. This form must be returned to ACUTE NURSING SOLUTIONS upon the completion of your shift. Please fax to: (480) 247-5621. We will not be responsible to pay you for time that is not submitted to us using this process.
3. Incidental overtime will not be paid unless authorized by the charge nurse upon completion of your shift.

CHARGE NURSE SIGNATURE REQUIRED FOR INCIDENTAL OVERTIME

AMOUNT OF OVERTIME:_____

REASON FOR OVERTIME:_____

CHARGE NURSE/MGR SIGNATURE:_____