**Employee:** ______________________ **Facility:** ______________________

**Skill:** ☐ CNA ☐ CMT ☐ LPN ☐ RN ☐ OTHER

| Date | Shift | Unit | Time In | Time Out | Lunch | Total Hours | Client Initial |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

☐ Time and Travel ☐ Late Call ☐ Other ______________

By signing I attest this slip to be accurate and true, if filled out incorrectly I understand that will result in a delay in payment. I understand any verified discrepancy will result in a future deduction from my pay and possible prosecution by law enforcement officials.

**Employee Signature:**

______________________________

**Daily Evaluation**

**E – Excellent G – Good F – Fair U - Unsatisfactory**

1. Meets dress code requirements E G F U
2. Patient care meets standards E G F U
3. Meets safety standards E G F U
4. Meets infection control standards E G F U
5. Documentation meets standards E G F U
6. Completes work timely E G F U
7. Follows directions E G F U
8. Cooperative w/ co-workers E G F U
9. Courteous to patients E G F U
10. Punctuality E G F U

**Client Agreement**

The signature of a client's authorized person verifies that the hours worked by Integrity Health Group personnel are accurate and work was performed satisfactorily. The signature also acknowledges that the client agrees not to employ or encourage employment of Integrity Health Group personnel for 90 days following the assignment. Client agrees to terms of net upon receipt. 1.5% is charged on all accounts past due over 30 days. Time and one half is charged for overtime and the seven national holidays. All court costs and legal fees will be the obligation of the client for the collection of delinquent accounts.

**Client Signature:** ______________________________

**Client Printed Name:** ______________________________

**Employee:** ______________________ **Facility:** ______________________

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