SBG® HEALTHCARE

Staffing Solutions for Employers of Physicians & Advanced Practitioners

QUALITY INTEGRITY SERVICE • QUALITY INTEGRITY SERVICE • QUALITY INTEGRITY SERVICE

CHECK ONE
☐ Direct Deposit
☐ Manual Check

Provider Name:________________________________ Facility:___________________________

My recruiter is: ________________________________

Provider Type (select one): [ ] Physician [ ] Advanced Practioner Other: ___________________________

Day of the Week	Date	Start Time	End Time	Regular Hours	After Shift Hours	Night Call	24hr Call
SUNDAY						[ ]	[ ]
MONDAY						[ ]	[ ]
TUESDAY						[ ]	[ ]
WEDNESDAY						[ ]	[ ]
THURSDAY						[ ]	[ ]
FRIDAY						[ ]	[ ]
SATURDAY						[ ]	[ ]
			TOTAL				

Call-Back Log

Date	From	To	Location	Call-Back Time Total
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
/ /				
			TOTAL	

Other reimbursable out-of-pocket expenses (*legible receipts must accompany this form for reimbursement*)

PLEASE NOTE: Any additional products or services purchased (e.g. GPS, additional insurance, satellite radio, etc.) are not covered by SBG Healthcare, and are the responsibility of the provider.

Date	Type	Description	Amount
/ /			
/ /			
/ /			
/ /			
		TOTAL	$

REQUIRED SIGNATURES

Provider Name (Print):____ Title: ____________________________

Provider Signature: ____ Date: ____________________________

*Provider: By signing this, I confirm that the hours and expenses reported here are true and correct and that these hours and expenses will be reviewed and paid in accordance as an independent contractor. I also understand that receipts must be processed at the same time as the shifts they apply to. **If a dollar amount is included on the timesheet and no receipt provided I agree that I am forfeiting the right to reimbursement for that expense.**

Client Name (Print):____ Title: ____________________________

Client Signature: ____ Date: ____________________________

* Client: By signing this, I confirm that the hours and expenses reported here are true and correct and understand that these hours and expenses will be reviewed and billed in accordance with agreed upon terms. Please call your client manager if there are any questions.

PLEASE FAX SIGNED FORM TO 305.999.6241 EACH MONDAY NO LATER THAN NOON (EST)