



Provider Name: _____

Facility: _____

My recruiter is: _____

Provider Type (select one): ☐ Physician ☐ Advanced Practioner

Other: _____

CHECK ONE

Direct Deposit

Manual Check

Day of the Week	Date	Start Time	End Time	Regular Hours	After Shift Hours	Night Call	24hr In House	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 <i>(legible receipts must accompany this form for reimbursement)</i>			
PLEASE NOTE: Any additional products or services purchased (e.g. GPS, additional insurance, satellite radio, etc.) are not covered by Epic Physician Staffing 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.	

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