



\*\*\*Please press *firmly*, so the faxed copy is legible.

**FAX (303) 757-7607**

Hospital (Client): \_\_\_\_\_

IMS Associate Name: \_\_\_\_\_ RN / RT / CN/

IMS Associate Signature: \_\_\_\_\_

Shift Start Date MM/DD/YY	Shift Worked	Start Time	Finish Time	Reg. Hours	OT Hours	Authorized Hospital/Client Signature	Unit or Floor
	D E N						
*** 30 minute break will be deducted from each shift greater than six hours.							
Nursing Supervisor / Dept. Manager approval (printed name and initials) is required for all scheduled shift.						Print Supervisor Name: _____	Supervisor Initials: _____
Use this section to give a brief explanation for _____							

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(White Copy) Client/Hospital

(Yellow Copy) IMS

(Pink Copy) IMS Associate