



Facility Call-Off Verification Form

Email To: HSGTimesheet@HealthSourceGlobal.com

To be completed by Employee:

Employee Name _____ Traveler ID: _____

Facility Name _____

Date(s) of Call Off(s)	# of Hours you are short	Reason
Example: 1/23/20	8	Call off due to low census

Employee Signature _____ Date: _____

To be completed by Facility:

Authorized Facility Signature _____ Date: _____

Facility Printed Name _____

Pursuant to the Healthcare Staffing Agreement, Facility shall provide healthcare professional a minimum work week.