



CLINICAL STAFFING OFFICE TIME ADJUSTMENT FORM

EMPLOYEE NAME: (Print) _____

EMPLOYEE NUMBER: _____

EMPLOYEE PHONE NUMBER: _____

DATE AND UNIT WORKED	TYPE OF CORRECTION DONE	CLOCK CODE AND TIME	REASON FOR MANUAL ENTRY
<p>_____ MM/DD/YY</p> <p>_____ UNIT/DEPARTMENT</p> <p>_____ ORG ID NUMBER</p>	<p><input type="checkbox"/> ADD</p> <p><input type="checkbox"/> DELETE</p> <p><input type="checkbox"/> CHANGE</p> <p><input type="checkbox"/> CANCEL MEAL DEDUCTION</p>	<p><input type="checkbox"/> IN</p> <p>_____ Time In</p> <p><input type="checkbox"/> OUT</p> <p>_____ Time Out</p> <p><input type="checkbox"/> FLOAT</p> <p>_____ (DEPT. AND ORG ID)</p>	<p><input type="checkbox"/> FORGOT TO CLOCK IN/OUT</p> <p><input type="checkbox"/> ENTERED INCORRECTLY</p> <p><input type="checkbox"/> FORGOT BADGE/NO BADGE</p> <p><input type="checkbox"/> NEW EMPLOYEE</p>

EMPLOYEE SIGNATURE

SUPERVISOR SIGNATURE

Use this form to make adjustments when clocking in or out was missed or done incorrectly. This form must be dated and department worked must be listed. Employee must sign and date this form. Supervisor (Nurse Manager or Charge Nurse) must sign form.
Forms that are not filled out properly with an authorized signature will result in a delay of payment.

CRITICAL NEEDS PAY AUTHORIZATION _____