Hospitalist Weekly Extra Shift Compensation Form

Provider Name: _____

Home Division: _____

Check Type of Shift Covered:

☐ Full Night MD shift 7p-7a ☐ Full day MD shift 7a-7p ☐ Full Day APP shift 7a-7p

☐ Full Night APP shift 6p-7a ☐ Swing shift 5p-11p

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

Date of shift:_____Time:_____Total Hours_____

_____ Date_____

Provider Signature

_____Date_____

Brandee Lemaire (Administrative Approval)

Date scanned and sent to UTP Payroll: _____

Total 12hr shifts_____ _ X $_____ = _____

Total 6hr shifts_____ _ X $_____ __= _____

Total $_____