

## 24/7 STAFFING SOLUTIONS ADVANCE PAY REQUEST

Please fax this request to: (562) 685-0911 or email it to: [info@24-7ss.com](mailto:info@24-7ss.com)

All requests must be submitted by noon to be processed by 3:00pm that same day.

This form is available to print from our website: [www.24-7ss.com](http://www.24-7ss.com) or can be picked up from our office.

|  |                          |                          |                          |                          |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>NAME OF NURSE/TITLE:</b><br>(Please Print Legibly. If we are unable to read this request it will not be processed.) |                          |                          |                          |                          |
|  |                          |                          |                          |                          |
| <b>DATE OF SERVICE:</b>  |                          |                          |                          |                          |
| <b>FACILITY:</b>   |                          |                          |                          |                          |
| <b>UNIT:</b>   |                          |                          |                          |                          |
| <b>SHIFT:</b>  |                          |                          |                          |                          |
| <b>HOURS:</b>  | Reg. _____<br>O.T. _____ | Reg. _____<br>O.T. _____ | Reg. _____<br>O.T. _____ | Reg. _____<br>O.T. _____ |

By signing below you are verifying that all information provided above is correct and accurate. If time on faxed sign-in sheet from facility differs from information provided above, corrections will be made on your following check.

Employee Signature: \_\_\_\_\_

Please Circle One:      Mail      Direct Deposit      Pick Up

**FOR OFFICE USE ONLY. DO NOT WRITE BELOW THIS LINE.**

Verified By: \_\_\_\_\_ Date Verified: \_\_\_\_\_

Verified With: \_\_\_\_\_ Time Verified: \_\_\_\_\_

Registry / Travel (circle one)

**For Accounting Use Only**

Rate: \_\_\_\_\_ OT Rate: \_\_\_\_\_ Housing / Non Housing (circle one)

Check Date: \_\_\_\_\_ Check Number: \_\_\_\_\_ Direct Deposit Date: \_\_\_\_\_

Amount of Paycheck: \_\_\_\_\_ Amount of Housing Check: \_\_\_\_\_ (if applicable)

Withholding: \_\_\_\_\_ Housing Check Number: \_\_\_\_\_

Comments:

---



---



---