Nursing Department – Staffing Office
Phone: 315-464-6123

Employee OT/ET/*ReCall Verification Form

The purpose of this form is to verify **ALL ReCall hours worked in any unit, including home unit**; and to verify all **OT/ET (extra time) hours worked only in areas outside your home unit**.

Please return the completed form to the Staffing Office to ensure proper credit for hours worked. This form is required for all staff (PEF and CSEA) within the Nursing Department (except for Periop and Procedural areas working in home units).

Emp ID#:		**Employee Name:**			
Home Department:		**Title:**		**Date:**	

SECTION I: OT/ET/RECALL INFORMATION

Mgr/Supervisor/Clinical Leader: By signing below, I acknowledge that the below hours were worked in this department (transfer Department) by the below named employee.

IN TIME	OUT TIME	DEPT WORKED	INDICATE IF HRS ARE SACO/SUWA	INDICATE OT/ET/RECALL	SUPERVISOR/MANAGER/CLINICAL LEADER SIGNATURE	DATE

SECTION II: EMPLOYEE SIGNATURE

Employee- By signing below, I am verifying that the above hours were worked.

Employee Signature:		**Date**	

********For all **RECALL** in MED SURG, ICU, and ED this form must be signed by the Administrative Supervisor**********