INGALLS MEMORIAL HOSPITAL
OVERSHIFT TIME & OVERTIME REQUISITION

AGENCY NURSES ARE EXPECTED TO PROACTIVELY COMMUNICATE WITH THE SUPERVISOR OR AC, A MINIMUM OF 1 HOUR PRIOR TO THE END OF THEIR SHIFT

Date:
Time of Request:
Name:
Department:
Shift Start Time:
Shift End Time:
Reason for Overshift Time or Overtime:
Supervisor/AC ***(please print)*****:**
Supervisor/AC Signature:

Please fax this requisition to 630.791.2946