

Mediscan Overtime Request Form



Mediscan Employee Name: _____ Facility: _____

I am requesting to work overtime for the following reason(s):

Day of the week: _____ Date requesting overtime: _____

From the hours of: _____ AM PM to _____ AM PM

I understand that:

1. A separate written request is required for each occasion that I request overtime.
2. My overtime request must be approved in writing before I work the requested overtime.
3. Signed overtime request form must be attached to my time card for payment.
4. If I work overtime without written authorization, I will be subject to disciplinary action.
5. Should overtime be approved, I will be paid as follows:
 - Hours beyond 8 in a workday = 1.5 (time and a half)
 - Hours beyond 12 in a workday = 2.0 (double time)
 - Hours beyond 40 straight-time hours in a workweek = 1.5 (time and half)

Employee Signature: _____ Date Request Submitted: _____

For Facility Supervisor/Manager Use Only:

Check One:

- Your overtime request has been approved.
- You may work the overtime you requested, but must work the following overtime hours rather than those submitted in your request:

- Your overtime request has been denied.

By _____ Name: _____
Supervisor Signature Please Print Name

Title: _____ Date: _____

Facility approval of OT indicates that OT hours are billed and payable to Mediscan.

PLEASE FAX THIS APPROVAL TO MEDISCAN 818-758-4220