

# TRAINEE INTERN WORK FORM



**YOUR NAME**

**DATE OF SHIFT**

**TYPE OF SHIFT**

**DEPARTMENT OR RUN**

**HOSPITAL**

**POSITION OF RMO COVERING FOR**

**BRIEF DESCRIPTION OF THE WORK PERFORMED, AND WHAT WORK WOULD BE CONSIDERED THAT OF A H/O**

**WERE YOU TOLD TO PERFORM THE WORK? IF SO, BY WHOM?**

**NUMBER OF HOURS CLAIMED FOR (TO BE PAID AT MINIMUM WAGE)**