



ADVANTAGE MEDICAL STAFFING

OFFICE: 904-823-1458

TOLL-FREE 1-800-381-1458

TOLL-FREE FAX 1-866-655-4347

(IF YOU FAX THIS TIME SLIP, CALL

TO CONFIRM FAX WAS RECEIVED)

Please Mark the day you worked with an X

Mon	Tue	Wed	Thu	Fri	Sat	Sun
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*Date Worked: _____

*Employee Name: _____

Start time: ___:___ a.m. or p.m.

End time: ___:___ a.m. or p.m.

30 minute lunch

30 minute lunch not taken must be approved by Supervisor, Supervisor initials: _____

*Total regular hours worked: ____.

Overtime hours: ___:___

*Name of Client: _____

*Unit assigned: _____ Floated to: _____

PayCard or Direct Deposit

*Classification: _____ (RN, LPN or CNA)

I certify that the hours shown above represent my total hours worked and that they were properly verified by the client or by an authorized representative. I understand I must report for reassignment upon conclusion of each assignment, and that unemployment benefits may be denied for failure to report.

*Employee Signature: _____

*Signature of Client: _____

I agree to terms of net upon receipt and to pay interest on unpaid accounts over 30 days at the rate of 10% per annum, together with all collection & litigation costs, plus interest and reasonable attorney's fees. I recognize the rights of ADVANTAGE MEDICAL STAFFING as the employer and I agree not to employ directly in any capacity the person named heron without first providing ADVANTAGE MEDICAL STAFFING with at least (30) working days written notice following the termination of this agreement. I certify that the hours shown above are correct and that the employee performed satisfactorily.



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