12345 West 95th Street, Suite 215
Lenexa, KS 66215
Ph# (913) 438-6337
Fax# (913) 438-1998

____
Employee Name (Print)

____
Last 4 digits of SSN

____
Client Facility
Week Ending (Sat) ____________

Day	Date	Start	End	*Meal Break (Yes/No)	Hours	Unit	Approved Signature
Sun							
Mon							
Tue							
Wed							
Thur							
Fri							
Sat							

Total Hours

* All lunches not taken must be initialed by appropriate supervisor.

Client Signature:____

Client: I certify that the hours listed above are correct and work was performed satisfactorily. I recognize the rights of Health Specialists, Inc. (HSI), as employer and agree not to employ the above named individual for a period of 90 days from completion of assignment. I understand that upon violation of this condition, I will pay $10,000 to HSI as liquidated damages.

Employee Signature: ______________________________________

Employee: I certify that the hours and days shown reflect a complete account of the time actually worked