



OR·NURSES·INC

PROFESSIONALS FOR SPECIALTY STAFFING

Employee Name: _____ Client Name: _____

Title: _____ Week Ending: _____

Employee:

I certify that the time worked as shown is true and accurate and was worked by me during the days indicated and was properly certified by the client or clients' representative at the bottom thereof. I also certify that I did not receive any injuries during this assignment. I understand that I am to contact O.R. Nurses, Inc. immediately after completing the assignment.

ALL UNSIGNED TIME SLIPS WILL BE RETURNED TO THE EMPLOYEE WITHOUT A CHECK

SIGNATURE X: _____

DAY	DATE	UNIT	TIME STARTED	TIME FINISHED	LUNCH	TOTAL	APPROVAL	O.R. NURSES
SUNDAY								
MONDAY								
TUESDAY								
WEDNESDAY								
THURSDAY								
FRIDAY								
SATURDAY								
TOTAL TIMES FOR WEEK TO NEAREST ¼ HOUR								

CLIENT SHALL NOT PAY OR ADVANCE ANY MONEY TO EMPLOYEE AND MAY NOT ASSERT ANY SUCH PAYMENT AS A SETOFF AGAINST O.R. NURSES, INC.

CLIENT SIGNATURE X: _____

ATTENTION: Please have charge nurse sign each shift completed above.

COMMENTS: