

Wise Medical Staffing Services, Inc

Week Beginning _____

Week Ending _____

Employee's Name _____

Day	Start	End	Lunch	Total Hours
Sunday	AM	AM		
	PM	PM		
Monday	AM	AM		
	PM	PM		
Tuesday	AM	AM		
	PM	PM		
Wednesday	AM	AM		
	PM	PM		
Thursday	AM	AM		
	PM	PM		
Friday	AM	AM		
	PM	PM		
Saturday	AM	AM		
	PM	PM		
TOTAL WEEK				

I certify that the days and hours shown are correct and were Worked by me. I certify that I received no injuries for the above period.

Employee's Signature

Date

I certify that the above is a true and correct statement. I (the client) agree to pay Wise Staffing Services, Inc. the amount agreed upon for the above hours. In the event of default on my part to any terms of agreement, I (the client) agree to pay all court cost, a reasonable lawyer fee and all other collection cost.

Manager's Signature

Date

Customer Name