Wise Medical Staffing Services, Inc

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Week Beginning Week Ending

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Employee's Name

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

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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.
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Manager's Signature Date

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Customer Name