



P.O. Box 7084  
West Reading, PA 19611

(P): 484-706-3567  
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lifespammedical@gmail.com

EMPLOYEE NAME \_\_\_\_\_ FACILITY \_\_\_\_\_ WEEK/DATE \_\_\_\_\_

DAY	DATE	TIME IN	TIME OUT	LUNCH	TOTAL HRS	UNIT	AUTHORIZED SIGNATURES	NOTES
							<b>TOTAL HOURS WORKED</b>	

TERMS AND CONDITIONS: (1) Client agrees that the undersigned is an authorized representative of the client. Client signature on time slip is understood to have authorization and is binding upon the client. Client signature on Lifespan Medical Personnel, Inc. employee's time slip certifies satisfaction of duties performed and total number of hours worked. (2) Client agrees to pay invoices upon receipt. A late charge of 1.5% per month (annual interest rate of 18%) will be added to all balances remaining after 14 days. Client agrees to pay all reasonable collection fees, including attorneys and court fees, related to unpaid balances. (3) Client agrees to notify Lifespan Medical Personnel Inc. of all cancellations a minimum of four hours prior to the start of any Lifespan Medical Personnel, Inc. employee's schedule shift. Client agrees to pay Lifespan Medical Personnel Inc. the sum equal to 4 hours pay at the agreed upon rate, if the client fails to make notification within the specified time period. Client also agrees to pay the sum of 4 hours pay if any Lifespan Medical Personnel, Inc. employee is sent home after reporting for a schedule shift. (4) Client agrees not to directly hire the employee listed. If client desires to directly hire the employee, client agrees to terms listed in contract.

Employee: \_\_\_\_\_

I certify that I have worked the hours shown here and have had them verified by the authorized client. I also certify that I have not sustained any on the job injury, unless noted on this time card.

Employee Signature: \_\_\_\_\_

PLEASE MAKE A COPY FOR YOUR RECORDS