



WEEKLY TIME SHEET

FAX TIME SHEET NO LATER THAN 10PM SUNDAY:

FAX # (866) 899-8967

Technician Name:
Facility Name & Department:
Facility Address:
Supervisor Name:
Department Phone Number:

Day	Date	Time In	Time Out	Lunch	Total Hours Less Lunch	Total O.T Hours
SUN					0:00	0:00
MON					0:00	0:00
TUES					0:00	0:00
WED					0:00	0:00
THURS					0:00	0:00
FRI					0:00	0:00
SAT					0:00	0:00
TOTAL					0:00	0:00

Overtime Hours Only				Call Back Hours Only			
Day	Date	Time In	Time Out	Day	Date	Time In	Time Out
SUN				SUN			
MON				MON			
TUES				TUES			
WED				WED			
THURS				THURS			
FRI				FRI			
SAT				SAT			
TOTAL				TOTAL			

I certify the hours shown above were worked by me during the week designated and was verified by authorized personnel. I certify that no injuries or accidents were sustained by me while working on this assignment unless so noted. I agree to contact EMG Staffing after the completion of my assignment. If I fail to do so EMG Staffing may assume that I am not available to work.

Technician Signature:	Date:
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I hereby certify the above named employee has performed satisfactory service for the day/s and times indicated and authorize billing for services performed. In the event the above named individual is hired by the facility or subsidiary within the time period specified in the contract, I agree to pay EMG Staffing a fee per contract agreement.

Client Signature:	Date:
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