MAS MEDICAL STAFFING
PERM • TRAVEL • PER DIEM • HOME CARE

1243 Mineral Spring Ave, Suite 208
North Providence, RI 02904
T 401 724 6300
F 401 724 7900
Call us toll free 877 950 6300

Employee Name: ________________________ Client Name: ________________________

Instant Pay_________
VISA_______________

Classification: RN LPN CNA

Pay Period Ending ______/______/_____

Amount $____________

Check #____________

Time sheets must be faxed by 3:00 pm Monday to 401.724.7900

Note: Altered or unsigned time cards will not be accepted. In the event of an error please complete a new time card.

DAY	**DATE**	*nearest ¼ hr **TIME IN**	Client Initial **SIGN IN**	*nearest ¼ hr **TIME OUT**	*Do not leave Blank **LUNCH**	**TOTAL HOURS**	****Authorized Signature/ Date**
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday **End of Week**							

I hereby certify that I worked the hours outlined above at the facility stated above, and that these hours were verified by the authorized representative of the Client.

____
MAS Medical Staffing Employee's Signature

TOTAL HOURS FOR THE WEEK_________

**CLIENT VERIFICATION:

I hereby certify that the above named individual has worked the hours listed above, that the work was performed to satisfaction of the client, and that payment is hereby approved. I agree not to employ, directly or indirectly, for a period of 6 months from this date, the above named healthcare provider, and agree to pay liquidation damages to MAS Medical Staffing according to the following schedule: $5000 if hired within 6 months of initial employment and $2500 if hired after 6 month of initial employment.

Authorized Signature: ____________________________________ **Date:** ____________________