MED FIRST		PHONE: (864) 421-0394 TOLL FREE PHONE: (888) 421-039 FAX: (864) 421-0397 TOLL FREE FAX: (877) 421-0397 payroll@medfirststaffing.com					SUPERVISOR SIGNA	TURE By my si	gnature I agree to the	terms and conditions o	n the reverse side.	
FIRST NAME M.I.		LAST NAME			CUSTOMER NAME JOB SITE / UNIT #							
EMPLOYEE SIGNATURE			LAST 4 NUMBERS OF SSN			EMPLOYEES: CHECK THE APPROPRIATE BOX(ES) BELOW AFTER EACH SHIFT WORKED. HOLD CHECK						
DAY	DAY DATE TIME IN TIME OUT		LESS LUNCH TOTAL HOURS		SUPERVISOR	I HAVE RECEIVED A WORK-RELATED INJURY DURING THIS SHIFT*			I HAVE WITNESSED A MEDFIRST WORK- RELATED INJURY DURING THIS SHIFT*			
SUN	37112			PERIOD	1011121100115	INITIALS	YES	NO NO	YES	NO NO	CHECK	
MON							YES	NO NO	YES	NO NO	*IF YOU ARE INJURED	
TUE							YES	NO NO	YES	NO NO	ON THE JOB, OR WITNESS ANOTHER	
WED							YES	NO NO	YES	NO NO	MEDFIRST EMPLOYEE GET INJURED ON THE	
THU							YES	NO NO	YES	NO NO	JOB, IT IS YOUR RESPONSIBILITY TO	
FRI							YES	NO NO	YES	NO NO	ONCE TO PROVIDE	
SAT							YES	NO NO	YES	NO NO	DETAILS.	
	HOURS WORKED			TOTAL			CIRCLE YOUR TITL	E: NP RN	LPN CI	MA CNA	OTHER	
HOURS: SHADED AR	REA FOR	MINUTES: REGULAR		OVERTIME OVERTIME		HOLIDAY		TOTAL		NOTES:		
OFFICE USE	ONLY	HOURS:		HOURS:		HOURS:		HOURS:		NOTES:		
FIRST NAM	PHONE: (864) 421-0394 TOLL FREE PHONE: (888) 421-0397 FAX: (864) 421-0397 TOLL FREE FAX: (877) 421-0397 payroll@medfirststaffing.com    M.I.   LAST NAME   M.I.   M.I.   LAST NAME   M.I.   M						SUPERVISOR SIGNATURE  By my signature I agree to the terms and conditions on the reverse side.  CUSTOMER NAME  JOB SITE / UNIT #					
51.181.81/55					l						<del>-</del>	
EMPLOYEE SIGNATURE					LAST 4 NUMBERS	2 OF 22M		EMPLOYEES: CHECK THE APPROPRIATE BOX(ES) BELOW AFTER EACH SHIFT WORKED. HOLD CHECK				
DAY	DATE	TIME IN	TIME OUT	LESS LUNCH PERIOD	TOTAL HOURS	SUPERVISOR INITIALS		A WORK-RELATED INJUR' G THIS SHIFT*		ED A MEDFIRST WORK- Y DURING THIS SHIFT*	MAIL CHECK	
SUN							YES	NO	YES	NO		
MON							YES	NO	YES	NO	*IF YOU ARE INJURED ON THE JOB, OR	
TUE							YES	NO	YES	NO	WITNESS ANOTHER MEDFIRST EMPLOYEE	
WED							YES	NO	YES	NO	GET INJURED ON THE JOB, IT IS YOUR	
THU							YES	NO	YES	NO	RESPONSIBILITY TO NOTIFY MEDFIRST AT	
FRI							YES	NO	YES	NO	ONCE TO PROVIDE DETAILS.	
SAT							YES	NO	YES	NO		
WRITE OUT HOURS:	HOURS WORKED	MINUTES: TOTAL HOURS				CIRCLE YOUR TITLE: NP RN LPN CMA CNA OTHER				OTHER		
	HADED AREA FOR REGULAR  OFFICE USE ONLY HOURS:				HOLIDAY HOURS:	TOTAL HOURS:		NOTES:				
FIRST NAM	<b>ED</b> RST	PHONE: (864 FAX: (864) 42	21-0397		HONE: (888) 42 AX: (877) 421-0 ng.com		SUPERVISOR SIGNA	TURE By my si	gnature I agree to the	terms and conditions o	n the reverse side.	
THOTNAME		191.11.		LASTIVAIVIE			COSTOMERNAME			JOB SITE / ONIT #		
EMPLOYEE	SIGNATURE					LAST 4 NUMBERS OF SSN		EMPLOYEES: CHECK THE APPROPRIATE BO		X(ES) BELOW AFTER EACH SHIFT WORKED. HO		
DAY	DATE	TIME IN	TIME OUT	LESS LUNCH PERIOD	TOTAL HOURS	SUPERVISOR INITIALS		A WORK-RELATED INJURY G THIS SHIFT*		ED A MEDFIRST WORK- Y DURING THIS SHIFT*	MAIL CHECK	
SUN							YES	NO	YES	NO		
MON							YES	NO	YES	NO	*IF YOU ARE INJURED ON THE JOB, OR	
TUE							YES	NO	YES	NO	WITNESS ANOTHER MEDFIRST EMPLOYEE	
WED							YES	NO	YES	NO	GET INJURED ON THE JOB, IT IS YOUR	
THU							YES	NO	YES	NO	RESPONSIBILITY TO NOTIFY MEDFIRST AT	
FRI							YES	NO	YES	NO	ONCE TO PROVIDE DETAILS.	
SAT							YES	NO	YES	NO		
WRITE OUT HOURS:	HOURS WORKED	MINUTES:		TOTAL HOURS			CIRCLE YOUR TITL	E: NP RN	LPN CN	MA CNA	OTHER	
SHADED AREA FOR OFFICE USE ONLY		REGULAR HOURS:		OVERTIME HOURS:		HOLIDAY HOURS:		TOTAL NOTES:		NOTES:		

SUPERVISOR SIGNATURE

By my signature I agree to the terms and conditions on the reverse side.