MEDFIRST

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SUPERVISOR SIGNATURE *By my signature I agree to the terms and conditions on 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 ☐
MAIL CHECK ☐

DAY	DATE	TIME IN	TIME OUT	LESS LUNCH PERIOD	TOTAL HOURS	SUPERVISOR INITIALS	I HAVE RECEIVED A WORK-RELATED INJURY DURING THIS SHIFT*	I HAVE WITNESSED A MEDFIRST WORK-RELATED INJURY DURING THIS SHIFT*
SUN							YES ☐ NO ☐	YES ☐ NO ☐
MON							YES ☐ NO ☐	YES ☐ NO ☐
TUE							YES ☐ NO ☐	YES ☐ NO ☐
WED							YES ☐ NO ☐	YES ☐ NO ☐
THU							YES ☐ NO ☐	YES ☐ NO ☐
FRI							YES ☐ NO ☐	YES ☐ NO ☐
SAT							YES ☐ NO ☐	YES ☐ NO ☐
WRITE OUT HOURS WORKED HOURS:		MINUTES:		**TOTAL HOURS**			CIRCLE YOUR TITLE:	NP RN LPN CMA CNA OTHER_____

*IF YOU ARE INJURED ON THE JOB, OR WITNESS ANOTHER MEDFIRST EMPLOYEE GET INJURED ON THE JOB, IT IS YOUR RESPONSIBILITY TO NOTIFY MEDFIRST AT ONCE TO PROVIDE DETAILS.

SHADED AREA FOR OFFICE USE ONLY	REGULAR HOURS:	OVERTIME HOURS:	HOLIDAY HOURS:	TOTAL HOURS:	NOTES: