PHONE: (864) 421-0394 TOLL FREE PHONE: (888) 421-0395
FAX: (864) 421-0397 TOLL FREE FAX: (877) 421-0397
**payroll@medfirststaffing.com**

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.*

| 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<br>HOURS: MINUTES: | | | | **TOTAL HOURS** | | | | | | |

HOLD CHECK ☐

MAIL CHECK ☐

*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.

CIRCLE YOUR TITLE: NP RN LPN CMA CNA OTHER____________

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