MEDPLUS

1 Copy – Customer
1 Copy – Employee
2 Copies - Office

EMPLOYEE NAME (Please Print)	
SOCIAL SECURITY #	**(RN,LPN,CNA,ETC.)**
CUSTOMER NAME	**DEPARTMENT**

DATE	**MONTH / DAY**	**TIME IN**	**TIME OUT**	**LUNCH**	**TOTAL HOURS**

WEEK ENDING DATE	**TOTAL HOURS WORKED**

Customer's Signature Certifies:
1) That the above hours are correct and that the work was performed in a satisfactory manner. 2) Confirms completion of Facility Unit orientation. 3) Confirms prior agreement between MedPlus and the customer with respect to the services performed.

_____
CUSTOMER SIGNATURE DATE

Employee signature and initials certifies that the following have been covered in the facility/unit Orientation:
1) Job Description ____ 2) Safety Policy____ 3) Occurrence Report ____ 4) Infection Control____ 5) Emergency Team____ 6) Other Information as Deemed Necessary by the Facility ____ 7) Hazard Communication____8)Evacuation____9)Soiled Utilities Location___ 10)Location of Bio Waste Containers___11)Review Policy & Procedures Book for Specific Facility____12)Unit Orientated_____
A) That the hours and dates shown above are true and correct, and were verified by an authorized representative of the Customer. B) MedPlus may assume that the employee is unavailable for work if he/she does not contact them upon completion of each assignment. C) No accident or injury was sustained during the dates shown above unless noted.

_____
EMPLOYEE SIGNATURE DATE