



1 Copy-Customer
1 Copy-Employee
1 Copy-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 Procedures ____ 9) Soiled Utilities Location ____ 10) Location of Bio Waste Containers ____ 11) Review Policy & Procedure 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		



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