

Due By 10am on Monday of Payroll Week- NO EXCEPTIONS!!!



H1N1 STAFF TIME SLIP

(O) 210-616-9526 (FAX) 210-545-0271
(FAX) 210-616-9501

Employee Name (print): _____

Work Week: _____ / _____ / _____ thru: _____ / _____ / _____

Last 4 #'s of SSN: _____ Clinic Location: _____

	Date	Start	Break	End	Reg Hrs	Apprvd	OT	OT Apprvd
Sun								
Mon								
Tue								
Wed								
Thur								
Fri								
Sat								

Total Hrs. Req

	Date	Start	Break	End	Reg Hrs	Apprvd	OT	OT Apprvd
Sun								
Mon								
Tue								
Wed								
Thur								
Fri								
Sat								

Total Hrs. Req

14 day period totals:

I certify no accident or injury was sustained by me while working on assignment unless otherwise noted. Should an injury occur while at work I am responsible for completing an incident report before the end of shift and also contacting Angel Staffing Incorporated for instructions for care. I certify the hours listed above were worked by me and properly certified by an authorized representative of named Client on time slip. I understand that I cannot be paid until I present a time slip that has been signed by me and approved by Client representative. By signing below, I agree that if I am overpaid at any time, I authorize the overpayment to be withdrawn from my next paycheck.

Employee Signature _____ Date _____

By signing this time slip as a representative of the above stated Client, you are certifying that the hours above are correct and that the work was performed in a satisfactory manner. This signature also authorizes that any overtime/holiday hours marked and initialed above are true and correct.

Client Authorized Signature _____ Date _____

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