



CONTRACTOR TIME SLIP

(O) 210-616-9526 (F) 210-545-0271

Last 4 Contract # _____

Print Employee Name _____

Facility/Unit _____

Work Week ____/____/____ thru ____/____/____

CLIN _____

	Date	Shift Start	Break	Shift End	Total Reg. hrs	Approval	OT Hrs	OT Approval	Holiday Hrs	Requested PTO Hrs	On Call Hrs
Sun											
Mon											
Tue											
Wed											
Thur											
Fri											
Sat											

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Sun											
Mon											
Tue											
Wed											
Thur											
Fri											
Sat											

*** MUST BE COMPLETED AT THE END OF PAY PERIOD ***

EMPLOYEE PERFORMANCE EXPECTATIONS	EXCEEDS	MEETS	UNSATISFACTORY
Promptness			
Technical Competency			
Team Player			
Completeness			
Emotional Stability			

14 Day Period Totals	
Reg. Hrs	
OT Hrs	
Holiday Hrs	
PTO Hrs	

Evaluators Signature _____

Evaluators Contact # or email: _____

*I certify no accident/injury was sustained by me while working on assignment unless otherwise noted. Should an injury occur while at work, I am responsible for filling out an incident report before the end of the shift and also contact Angel Staffing, Inc 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 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 By Signing Below I agree that if I am overpaid at anytime I authorize the overpayment to be withdrawn from my next pay check.

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 _____