STAFFING SERVICE

FAX: 336-291-1015

TIME SLIP/INVOICE

FULL NAME	CONTRACTOR ID #

CLASS -CIRCLE ONE

CNA LPN RN

VOID AFTER 30 DAYS

FACILITY

DAY	Date	Time IN	Time OUT	Unit	Total	Fac. Int.
SAT						
SUN						
MON						
TUE						
WED						
THU						
FRI						
		Total hours for week				

I hereby certify that this record correctly and adequately reports all hours brokered by Facility/Client

THIS INVOICE IS DUE AND PAYABLE UPON RECEIPT FOR THE CONTRACTED RATE

SIGNATURE **DATE**

NO LUNCH __________

Being duly authorized on behalf of the above facility, the undersigned hereby certifies that the above hours are correct and that the work was performed in a satisfactory manner.

FACILITY APPROVAL **TITLE**

WHITE COPY - STAFFING SERVICE
YELLOW COPY - INDEPENDENT CONTRACTOR
PINK COPY - LEAVE AT FACILITY