Around the Clock Healthcare Services, Inc.

Were MSDS and OSHA manuals reviewed? Yes ☐ No ☐	I completed a first report of injury during this assignment. Yes ☐ No ☐	Check One: Admin ☐ Clinical ☐	Occupation	Client # / Office #

Employee Name (Please Print)	Week Ending Date	Social Security Number	P.O. #	PLEASE PRESS DOWN FIRMLY WHEN COMPLETING INFORMATION

Company Name		Day/Date	Time Started	Time Finished	Less Meal	Total Reg. Hours	Total OT Hours	Miles	Area	Client Signature
Address		Sun								
		Mon								
		Tue								
City/State		Wed								
Department or Division		Thu								
		Fri								
		Sat								
		Equal Opprotunity Employer		Totals						

• All changes *MUST* be initialed by client including overtime or lack of mealtime

• Client acknowledges and hereby agrees to the terms and conditions on the reverse side of this time slip.

• All personnel certify that this form is true and accurate

Client Signature	Employee Signature	Accounting Use Only: Payroll Date	Check #

Routing Information
White: ATC Corporate
Green: ATC Corporate
Yellow: Local Office
Pink: Client
Goldenrod: HCA

Revised 5/99