



Name: \_\_\_\_\_

Week Ending: \_\_\_\_\_

Address: \_\_\_\_\_

Facility: \_\_\_\_\_

\_\_\_\_\_

Indicate how you would like your paycheck sent:

U.S. Mail      Direct Deposit       Priority       Overnight       Other \_\_\_\_\_

DAY	Date	Time In	Time Out	Hours Worked	Unit	
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						

Total Hours \_\_\_\_\_

**Employee:** By executing this form, employee agrees to and certifies that this form is true and accurate and that no injuries were suffered.

\_\_\_\_\_

Employee Signature                      Date

**Client:** By execution of this form, client certifies that: The above hours are correct and that the work was done in a satisfactory manner. Agrees to pay for services provided by Independent Nurse Consultants, Inc.

\_\_\_\_\_

Client Signature                                      Date

\_\_\_\_\_

Print Name

Fax to 1-800-816-0710 by 8pm Sunday