

USE SEPARATE SHEET FOR EACH FACILITY

Employee Name: _____

Employee Signature: * _____

*I certify that the hours shown on this time card are correct, that I performed this service, and that I did not suffer an unreported work related injury while on this assignment.

Last four digits of SSN: **XXX-XX-** _____

Client Name and Department: _____

Client City: _____

Round Total Daily Hours to Nearest 1/4 Hour

Date	Day	Start Time	AM	PM	Lunch Out	Lunch In	End Time	AM	PM	Regular Hrs	OT Hrs	On Call Hrs	Client Authorized Signature**	Payroll Use Only
	Mon.													
	Tues.													
	Wed.													
	Thur.													
	Fri.													
	Sat.													
	Sun.													

TOTAL HOURS TO BE PAID AND BILLED ⇒

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****Being an authorized representative of the customer, I have read, understand and agree to accept the following: I hereby,**

1. Agree that the total number of hours is correct and that the work was performed in a satisfactory manner.
2. Agree not to allow On Assignment Healthcare Staffing (OAI) employees to use unattended premises, cash, or valuables or allow such OAI employees to operate a motor vehicle without prior written authorization from OAI.
3. Understand that OAI insurance does not cover loss or damage caused by OAI employees operating customer owned or leased motor vehicles and therefore, the customer accepts full responsibility for any and all claims, including, defense hereof, involving bodily injury, fire, theft or property damage sustained or incurred as a result of an OAI employee driving such vehicle.
4. Agree to make all claims under OAI fidelity bond within 20 days after occurrence and understand that OAI does not accept responsibility for such claims if they are made after 20 days.
5. Understand that this account is due upon receipt and agree to pay all collection costs, including attorney's fees incurred in the collection of this account if not paid within 90 days.
6. Understand that during the term of this agreement and for one hundred eighty (180) days from Personnel's last date of active work with Client, Client agrees not to solicit Personnel, unless otherwise agreed to in writing. If any Personnel is hired, either directly or indirectly within that period, Client shall pay the following Conversion Fees, as measured by the hours of Personnel's completed temporary service through On Assignment:

Hours Completed:	0	170	340	520	690	860	1040
Percentage of Annual Compensation:	30%	21%	17%	13%	9%	5%	0%
7. Understand that acceptance of employees from On Assignment Healthcare Staffing constitutes acceptance of OAI's fee's and Terms and Conditions.

Mileage Reimbursement:

To ensure you are paid quickly and accurately, please provide the information requested on the timesheet. Failure to provide the necessary information may delay your paycheck. Be sure to call your OAI office if you have any questions.

Did you:

- *Clearly print your first name, last name and middle initial?
- *Sign your card and keep a copy for your records?
- *Record all hours and dates correctly?
- *Clearly print client name, department & city?
- *Obtain the appropriate signatures?

EQUAL OPPORTUNITY EMPLOYER