



CLIENT NAME
ADDRESS
REPORT TO

I hereby certify that the hours shown were worked by me during the week ending designated, and were approved and certified by an authorized representative of the Client. I understand that I must contact Impact Staffing Corp upon completion of my assignment. I further understand that if I do not contact Impact Staffing Corp to discuss another assignment, Impact Staffing Corp may assume that I am no longer available for work.

EMPLOYEE NAME (PLEASE PRINT)
EMPLOYEE SIGNATURE

DAY	DATE	TIME-IN	TIME-OUT	LESS LUNCH PERIOD	TOTAL HOURS
MON					
TUE					
WED					
THU					
FRI					
SAT					
SUN					
WEEK ENDING DATE (SUNDAY)					TOTAL HOURS FOR WEEK

FOUR HOUR MINIMUM PER DAY

<p>CLIENT AGREEMENT</p> <p>Please insure that any days not worked by employee are crossed out and hours for the week are totaled out. Client's signature indicates acceptance of hours worked and terms and conditions on the reverse side.</p> <p>X _____ TITLE _____</p>
