



WEEK ENDING	
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CLIENT'S NAME							
EMPLOYEE NAME					LICENSE NO.		
CIRCLE CLASSIFICATION							
RN LPN CNA CHHA OTHER _____							

DAY	DATE	TIME IN	LUNCH PERIOD	TIME OUT	HOURS WORKED	TRAVEL TIME	CLIENT INITIALS
Sun.							
Mon.							
Tues.							
Wed.							
Thur.							
Fri.							
Sat.							
TOTAL HOURS			TOTAL TRAVEL TIME				

I, the undersigned, certify that this is an accurate record of my working time during this week, and that these hours were properly verified by the client or by an authorized representative. I recognize the rights of SCS, Inc. as the employer and agree NOT to be employed by the client named above while I am employed by SCS, Inc. I also certify that no injury was incurred by me during this assignment.

Employee Sign Here:

I certify that the above hours are correct and that the employee performed his/her duties satisfactorily.
I recognize the right of SCS, Inc. as the employer and agree NOT to employ the person named above.

Authorized Client Signature:

Hourly	OT/Holiday	Overnight	Live-In	Miles

WHITE - SCS, INC. YELLOW - CLIENT



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WHITE - SCS, INC. YELLOW - CLIENT