



# CORNERSTONE

## Medical Staffing, LLC

(478) 452-3060 • Fax (478) 451-2959 • Pager 1-877-210-6956

YOUR NAME \_\_\_\_\_  
First Initial Last

\_\_\_\_\_  
Classification

\_\_\_\_\_  
Client/Facility Name

### ROUND TOTAL DAILY HOURS TO NEAREST 1/4 HOUR

(Circle)

Date: \_\_\_\_\_ Mon. Tues. Wed. Thur. Fri. Sat. Sun.

Area	Start Time		Finish Time		Lunch Time		Mileage	Total	
	Hr.	Min.	Hr.	Min.	Hr.	Min.		Hr.	Min.

**Pick Up Check**

**Mail Check**

**Mandatory 30 minute lunch - Anything worked other than schedule shift, ONA must be notified.**

By signing below I (Sub-Contractor) agree not to engage in services with this facility for a period of six (6) months from the date I last worked for Agency at this facility.

I certify that I sustained no injuries while on this assignment.

X \_\_\_\_\_

***Sub-Contractor Signature***

We certify that the above hours are correct. Client approval includes acceptance of terms and conditions of the Agreement with Agency.

X \_\_\_\_\_

***Client's Authorized Signature***

**EQUAL OPPORTUNITY EMPLOYER**

Original and Yellow - Agency • Pink - Facility • Gold - Nurse