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