



338 Plantation Street
 Worcester, MA 01604
 P 508 459 2424
 F 508 459 1520
 Call us toll free 866 569 2107

Employee Name: _____ Client Name: _____ Instant Pay _____
 Classification: RN LPN CNA Pay Period Ending ____/____/____ VISA _____
 Amount \$ _____
 Check # _____

👉 Time sheets must be faxed by 3:00 pm Monday to 508-459-1520

Note: Altered or unsigned time cards will not be accepted. In the event of an error please complete a new time card.

DAY	DATE	*nearest ¼ hr TIME IN	Client Initial SIGN IN	*nearest ¼ hr TIME OUT	*Do not leave Blank LUNCH	TOTAL HOURS	**Authorized Signature/ Date
Sunday							
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday End of Week							

I hereby certify that I worked the hours outlined above at the facility stated above, and that these hours were verified by the authorized representative of the Client.

 MAS Medical Staffing Employee's Signature

TOTAL HOURS FOR THE WEEK _____

****CLIENT VERIFICATION:**

I hereby certify that the above named individual has worked the hours listed above, that the work was performed to satisfaction of the client, and that payment is hereby approved. I agree not to employ, directly or indirectly, for a period of 6 months from this date, the above named healthcare provider, and agree to pay liquidation damages to MAS Medical Staffing according to the following schedule: \$5000 if hired within 6 months of initial employment and \$2500 if hired after 6 month of initial employment.

Authorized Signature: _____ **Date:** _____