



TIME REPORT

Your Full-Service Staffing Solution FOR OFFICE USE ONLY

Name (Last, First):

Week Ending:

Client:

Date	Day	In	Lunch Out	Lunch In	Out	Hours Wkd	Overtime
Total Hours:							

Did the employee meet your expectations in the following areas?

- | | | |
|---------------------|--------------------------|--------------------------|
| | Yes | No |
| Attendance | <input type="checkbox"/> | <input type="checkbox"/> |
| Quality of Work | <input type="checkbox"/> | <input type="checkbox"/> |
| Patient Care | <input type="checkbox"/> | <input type="checkbox"/> |
| Productivity | <input type="checkbox"/> | <input type="checkbox"/> |
| Overall Performance | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered no to any question, please explain:

CLIENT ACKNOWLEDGEMENT - I, an authorized agent of the facility/client listed above certify that the hours listed are correct and that the employee performed their duties in a satisfactory and professionally competent manner. I recognize the rights of Ultrasound Temps Inc. as the employer and agree not to employ or encourage employment of the above Ultrasound Temps Inc. employee for a period of ninety (90) days following the completion of any assignment. I further agree to comply with the terms of the Client Rate Schedule/Agreement.

Client/Facility Representative Signature: _____

EMPLOYEE ACKNOWLEDGEMENT - I certify that the above hours are a true representation of my time worked and that I have obtained an authorized signature from a facility/client representative. I recognize the rights of Ultrasound Temps Inc. as the employer and agree not to be employed by the facility individually or through an agent for a period of ninety (90) days following the termination of this assignment without approval of Ultrasound Temps Inc. I certify that no injury was incurred by me during this assignment.

Employee Signature: _____

** Must have client and Ultrasound Temps Inc. approval.*