Renhill Healthcare On Demand

FAX TO:
419-254-2917
DELIVER, MAIL, OR FAX BY MONDAY AT 5:00 P.M.

Customer Name:
Address:

I hereby certify that the hours shown hereon were worked by me during the pay period and were certified by an authorized representative of the customer. I understand that I am to contact Renhill Healthcare On Demand after completing this assignment to discuss another assignment; and, if I do not do so Renhill Healthcare On Demand may assume that I am not available for work and have voluntarily left my employment.

Employee Name (Print):	Period end date:

Day	Date	Time Started	Time Finished	Less Lunch Period	Total Hours
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					

Hours to be shown to nearest quarter hour	***Total Hours for period:***

I am an authorized representative of the above named customer. By signing this, I certify the Renhill Healthcare On Demand employee named above worked the number of hours as itemized above and that their work performance was satisfactory.
Pursuant to any agreement between Renhill Healthcare On Demand services and the above named customer, I further understand the above named employee will be paid from this document and the above named customer will be invoiced from this document.
Should you have any questions regarding any of the above, please contact your Renhill Healthcare On Demand Account Manager.

Customer's Approval	
Signature	Title

Renhill Healthcare on Demand
2650 N Reynolds Rd. Toledo, OH 43615

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