

Fax to **888 634 7179** or email to [info@perdiemstaffingllc.com](mailto:info@perdiemstaffingllc.com)

## All Time Slips must be received by the Friday of payroll week by 6 PM

	DATE	START TIME	START LUNCH	END LUNCH	END TIME	TOTAL HOURS
SAT						
SUN						
MON						
TUE						
WED						
THU						
FRI						
<b>Total Hours worked rounded up to the nearest 1/4 hour</b>						

### AUXILIARY

I certify that the times worked as shown are true and accurate and were worked by me during the days indicated and were properly certified by the dentist or dentist's representative. **I further certify that, in the next 12 months, I will not seek or accept employment directly or indirectly from this dentist or his or her staff without prior notification to Per Diem Staffing.**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Position:  Office Support  Assistant

Hygienist  Dentist

### DENTAL OFFICE

I have read the terms and conditions below and I agree to be bound by them. It is hereby agreed that the hours stated are correct and that the work was performed satisfactorily. **I further certify that, in the next 12 months, I will not seek to employ directly or indirectly, temporarily or permanently this Per Diem Staffing Professional without prior notification to Per Diem Staffing.**

Signature: \_\_\_\_\_

Printed: \_\_\_\_\_

Date: \_\_\_\_\_

Office: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_