American Healthcare

PERFECT PRESCRIPTION FOR PATIENT CARE

9450 Garland Rd. Suite 381-259, Dallas, TX 75218 Phone: 972-212-8780 Fax: 972-212-8781 www.ahcprovider.com

☐ Instant Pay ☐ Mail ☐ Pick Up

☐ Direct Deposit

No.

Employee Classification (Check One):

☐ RN ☐ LVN ☐ CNA ☐ OTHER (specify) _____

Employee Name:	
Client:	

	DATE	UNIT WORKED	TIME IN	TIME OUT	LUNCH	TOTAL HRS
SUNDAY						
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT. I UNDERSTAND THAT I MUST CONTACT THE AGENCY FOR REASSIGNMENT UPON COMPLETION OF ANY ASSIGNMENT, AND THAT UNEMPLOYMENT BENEFITS MAY BE DENIED IF I FAIL TO DO SO. I CERTFY THE HOURS SHOWN ABOVE REPRESENT MY TOTAL HOURS WORKED, AND THAT THE HOURS WERE CERTIFIED BY THE CLIENT.

EMPLOYEE SIGNATURE _____ DATE _____

IT IS UNDERSTOOD THAT THE UNDERSIGNED IS AN AUTHORIZED REPRSENTATIVE OF THE CLIENT/FACILITY, AND HEREBY CERTIFIES THAT THE ABOVE HOURS ARE CORRECT, AND THAT THE WORK WAS PERFORMED TO CLIENT/FACILITY SATISFACTION. THE INVOICE IS PAYABLE NET 10 DAYS WITH INTEREST OF 1½% PER MONTH, ON BALANCES OVER 10 DAYS. CLIENT/FACILITY SHALL BE LIABLE FOR ANY FEES, INTEREST AND/OR COMMISSIONS RESULTING FROM THIRD PARTY COLLECTION EFFORTS TO RECOVER UNPAID BALANCES. IF CLIENT/FACILITY DESIRES TO HIRE THIS PERSON ON A PERMANENT BASIS, WRITTEN NOTIFICATION MUST BE GIVEN TO AMERICAN HEALTHCAE, LLC. THE CLIENT SHALL NOT HIRE EMPLOYEE FOR A PERIOD OF 90 DAYS FROM NOTIFICATION OR CLIENT MUST PAY STANDARD FEE.

AUTHORIZED/CLIENT SIGNATURE _____ DATE _____