



A gentle hand and a caring touch

NTI MEDICAL

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Name of Employee (Please Print)

Name of Facility

IMPORTANT FOR EMPLOYEE: BY EXECUTING THIS FORM, EMPLOYEE AGREES TO TERMS AND CONDITIONS ON REVERSE SIDE; CERTIFIES THAT THIS FORM IS TRUE AND ACCURATE, AND THAT NO INJURIES WERE SUFFERED.

DAY	DATE	HOURS TO NEAREST QUARTER HOUR		
		TIME IN	TIME OUT	TOTAL HOURS
S U N				
M O N				
T U E				
W E D				
T H U R				
F R I				
S A T				
TOTAL HOURS:				

X

EMPLOYEE SIGNATURE

X

AUTHORIZED SIGNATURE (CLIENT)