

AgTa
Home Health Care and Nursing Inc.
Employee/Client Time Log Sheet

Client's/ Care Receiver's Name _____

Employee's Name _____

Employee Classification (circle one)

RN RPN PSW HCA HMK HSKP

Day	Date	Circle Shift	Location	Total Hours
Sat.		M A N		
Sun.		M A N		
Mon.		M A N		
Tues.		M A N		
Wed.		M A N		
Thur.		M A N		
Fri.		M A N		

Week ending Friday / /

M D Y

Total _____

I the undersigned certify that this is an accurate record of my working time during this week, and that these hours were properly verified by the client or by an authorized representative. **I recognize the rights of AgTa Home Health Care and Nursing Inc. as the employer and agree NOT to be employed by the client named above for a period of 90 days following the termination of this agreement.** I also certify that no injury was incurred to me or by me during this assignment.

Employee sign here _____

I certify that the above hours are correct and that the employee performed his/her duties satisfactorily. DO NOT pay our employees directly. AgTa Home Health Care and Nursing Inc. will pay employees bi-weekly.

I recognize the right of AgTa Home Health Care and Nursing Inc. as the employer and agree NOT to employ the person named above for a period of 90 days following the termination of this statement.

The client agrees to terms of Net upon receipt and to pay interest on unpaid accounts over 15 days at the rate of 1.5% per month (Annual Percentage Rate of 18%), or the legal interest rate , whichever is the lower, together with reasonable legal fees for cost of collection.

I also certify that no injury was incurred to the Care Receiver and no damage was incurred to the property and possessions of the Care Receiver during this assignment.

Authorized Client/Power of Attorney or Guardian Signature