

Please fax back to 856-494-1995
Thank You!

LMS

Legal Medical Staffing

INSTRUCTIONS, TERMS AND CONDITIONS

FAILURE TO PROPERLY COMPLETE TIMECARD AND MAIL BY FRIDAY EVENING WILL DELAY CHECK.

A SEPARATE TIMECARD MUST BE COMPLETED FOR EACH ASSIGNMENT WORKED PER WEEK AND REQUIRES EMPLOYEE SIGNATURE AND AUTHORIZED CLIENT SIGNATURE.

OVERTIME WILL BE BILLED AT TIME AND ONE-HALF. TIME WORKED OVER 40 HOURS PER WEEK IS CONSIDERED OVERTIME.

IT IS AGREED BY CLIENT AND EMPLOYEE THAT IF EMPLOYEE NAMED ON THIS TIMECARD IS MADE A DIRECT OFFER OF A TEMPORARY, FULL-TIME, OR PART-TIME POSITION IN ANY CAPACITY WITH CLIENT, REPRESENTATIVE OF CLIENT, ANY INDIVIDUAL SHARING SPACE IN CLIENT OFFICE OR CLIENT REFERRAL, CLIENT AND EMPLOYEE SHALL NOTIFY LMS PRIOR TO TEMPORARY, FULL-TIME, OR PART-TIME START DATE. IT IS FURTHER AGREED THAT CLIENT SHALL BE RESPONSIBLE FOR A PLACEMENT FEE AS DETAILED IN OUR FEE AGREEMENT PREVIOUSLY SENT TO CLIENT. EMPLOYEE MAY BE RESPONSIBLE FOR A PLACEMENT FEE IN THE EVENT EMPLOYEE FAILS TO CONTACT LMS UPON AN OFFER OF TEMPORARY, FULL-TIME OR PART-TIME EMPLOYMENT AS STATED ABOVE.

CLIENT ALSO AGREES THAT ACCEPTANCE OF ANY LMS TEMPORARY EMPLOYEE OR INTERVIEW WITH ANY INDIVIDUAL LMS DISCUSSES WITH CLIENT OR REFERS TO CLIENT, CONSTITUTES CLIENTS UNDERSTANDING OF THE ABOVE INSTRUCTIONS, TERMS AND CONDITIONS

THE ABOVE TERMS AND CONDITIONS SHALL BE IN EFFECT FOR A PERIOD OF TWELVE MONTHS FROM LAST TEMPORARY ASSIGNMENT DATE OR REFERRAL DATE

WEEK ENDING SUNDAY	MONTH	DAY	YEAR
EMPLOYEE NAME			
CLIENT NAME			
DEPT.			
LOCATION			

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO CONTACT LEGAL-MEDICAL STAFFING SERVICES, INC. IMMEDIATELY WHEN THE COMPLETION DATE OF AN ASSIGNMENT IS KNOWN TO ME. I CERTIFY THAT I HAVE WORKED THE HOURS LISTED BELOW AND THAT AN AUTHORIZED REPRESENTATIVE OF THE CLIENT HAS VERIFIED AND SIGNED STATING SAME. I HAVE ALSO READ AND AGREE TO THE INSTRUCTIONS, TERMS AND CONDITIONS STATED ON THE REVERSE SIDE OF EMPLOYEE COPY.

EMPLOYEE SIGNATURE

• REPORT ALL TIME TO THE NEAREST 1/4 HOUR •

DAY	TIME STARTED	TIME FINISHED	LESS LUNCH	TOTAL DAILY HOURS
MON				
TUES				
WED				
THURS				
FRI				
SAT				
SUN				

• Four (4) hour minimum per employee day •

TOTAL HOURS

STRAIGHT TIME	OVERTIME

I CERTIFY THAT I HAVE REVIEWED THE HOURS STATED ABOVE AND THAT SAME ARE CORRECT. I HAVE ALSO READ AND AGREE TO THE INSTRUCTIONS, TERMS AND CONDITIONS STATED ON THE REVERSE SIDE OF CLIENT COPY.

AUTHORIZED CLIENT SIGNATURE

TITLE

DATE

SEE REVERSE SIDE FOR INSTRUCTIONS, TERMS AND CONDITIONS

FIRST COPY - Client SECOND COPY - Employee THIRD COPY - Legal Medical

PLEASE PRINT AUTHORIZED SIGNATURES NAME