

Sedona Staffing Services

www.sedonagroup.com

EMPLOYEE TIME SHEET (Required)
 Please check one of the following: Industrial Clerical Tech/Prof. WEEK ENDING

CLIENT NAME _____
 ADDRESS _____
 CITY _____
 STATE, ZIP _____

NAME OF EMPLOYEE (print) _____
 SOCIAL SECURITY NUMBER _____

| DATE | DAY OF WEEK | IN | | OUT | | TOTAL | Employee Signature |
|-----------|-------------|----|-----|-----|-----|-------|--------------------|
| | | IN | OUT | IN | OUT | | |
| MONDAY | | | | | | | |
| TUESDAY | | | | | | | |
| WEDNESDAY | | | | | | | |
| THURSDAY | | | | | | | |
| FRIDAY | | | | | | | |
| SATURDAY | | | | | | | |
| SUNDAY | | | | | | | |
| TOTAL | | | | | | | |

Client Signature (Required) _____
 Authorization for Payment

Notice to Client and Employee: Your signature constitutes agreement with all terms expressed on the back of this time sheet.

CLIENT. Check box if employee reported a work-related injury to you this pay period.
 EMPLOYEE. Check box if you sustained a work-related injury this pay period.

S.G.00.008 Rev. 5/10/06
 WHITE - OFFICE COPY
 CANARY - CLIENT COPY
 PINK - EMPLOYEE COPY
 12450-DAB

HOURS WORKED: _____
 OFFICE USE ONLY: _____
 REG. _____
 O.T. _____
 TOTAL HOURS: _____

Job Code: _____
 Pay Rate: _____
 Bill Rate: _____
 MARK BOX IF ASSIGNMENT COMPLETE