IMMACULATE HEALTH CARE SERVICES, INC.

CORPORATE OFFICE:
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MARYLAND OFFICE:
9470 Annapolis Rd, Suite 413 Lanham MD 20706
Ph: 301.429.0058 Fx: 301.429.0029

Employee Name: _____ Employee Name: _____

Client Name: _____ Week Ending: _____

DAY	DATE	TIME IN	TIME OUT	VISIT TYPE	INSUR. TYPE	NUMBER OF HOURS/VISIT	CLIENT SIGNATURE
MONDAY							
TUESDAY							
WEDNESDAY							
THURSDAY							
FRIDAY							
SATURDAY							
SUNDAY							
					TOTAL		

Visit Type: 1= Therapeutic, 2= Now Billable Aide Visit, 3.= Initial Assessment, 4= Non Billable Nurse Visit
Insurance Code: MD - MEDICAID, H-HMO, PP-PRIVATE DUTY
FOR EMPLOYER: I Hereby validate that the hours were worked by me during the week ending shown above and were properly authorized by a representative of the named Client above on this slip.

Employee PLEASE READ
I, the undersigned certify that this is an accurate record of my working time and that these hours were authorized by the authorized representative. I certify that I have incurred no injury to myself nor the others during the performance of the contracted work. I further agree not to be employed by the client above for a period of 90 days following the completion of work.

Facility/Client: PLEASE READ
In consideration of the furnishing of Immaculate staff by Immaculate Health Care Services, Inc. The client facility shall not employ the care provider for a period of 90 days following the completion of assignment without written approval of Immaculate Health Care Services, Inc. There will be a fee charged to the facility if any staff is employed by client/facility.

_____ _____ _____ _____

EMPLOYEE SIGNATURE DATE AUTHORIZED SIGNATURE DATE