WEEKLY TIME SHEET

SUPERVISOR NAME -TITLE



CLIENT COMPANY NAME WEEK ENDING

NUMBER & STREET CITY - STATE -ZIP

Ref. No.

www.BestChoiceStaffing.com ClientServices@BestChoiceStaffing.com Phone & Text: 561-515-0090			SUPERVISOR NAME - ITTLE								Ker. No.
			MONDAY	TUESDAY	WEDNESDAY		FRIDAY	SATURDAY	SUNDAY	_	l <u> </u>
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EASE PRINT CLIENT NAME		TITLE By execution of this form, CLIENT certifies that: work was done satisfactorily; that no one was injured on the job and that CLIENT					REGULAR				
THORIZED SIGNATURE			agrees with the terms and conditions set forth in the staffing agreement.								