TIME SHEET

Dental / Medical Associates, Inc.
P.O. Box 273
White Marsh, MD 21162
410-583-7227 Fax 410-256-1762

Employee Name: **Circle One:** DA RDH DDS FD

Practice Name: **Practice Address:**

Contact Person: **Name of Dentist:**

Day	Date	Time In	Lunch Out	Lunch In	Time Out	Daily Total Hours Worked
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
TEMPORARY AUXILIARY		**TOTAL HOURS WORKED FOR THE WEEK:**				

TEMOPORARY EMPLOYEE INSTRUCTIONS:

- Report your time in hours and minutes.
- The timesheet MUST be signed by you and the Practices authorized supervisor before the timesheet can be processed.
- To prevent delays in processing, please fill out the timesheet in its entirety and legibly.
- Payday is Saturday following the week worked. Fax this timesheet to 410-256-1762 by 6:00pm Friday. Note: If you finish an assignment mid-week, fax the timesheet on your last day. It is the **Temporary Employee's responsibility to make sure the timesheet is faxed**.
- If you are unable to report to work or will be late, it is pertinent that you call DMA at 410-583-7227 right away.

FAX TIMESHEET TO 410-256-1762 BY FRIDAY 6:00PM. LATE TIMESHEETS WILL BE PROCESSED THE FOLLOWING PAY PERIOD.

I certify that the time worked as shown is true and accurate and was worked by me during the days in the indicated week and was properly certified by the doctor or the Doctor's representative. I further certify that I will not seek or accept employment directly or indirectly from this Doctor or the staff without prior notification to Dental Medical Associates.

EMPLOYEE SIGNATURE: **Date:**

Terms and Conditions

1. Charges for services provided under this agreement will be billed at the hourly or daily rate specified in the fee schedule effective on the date this hour verification is signed.
2. This hour verification reflects the actual hours worked. However, it is agreed that Dental / Medical Associates, Inc. Will charge and payment will be made, for a minimum of four consecutive hours per day. Overtime hours (more than 8.25 hours per day) will be billed at 1.5 times the hourly rate.
3. Fees for Temporary Hygienists are billed at an hourly rate for up to 6.25 hours: 6.5 to 8.0 hours are billed as eight hours. A four consecutive hour minimum also applies.
4. All requests for Dental / Medical Associates Temporaries will be made through Dental / Medical Associates. If any agency Temporary is solicited for temporary work by the client signing this hour verification within 12 months from the date this hour verification was signed; the client agrees to pay to Dental Medical Associates its regular charge for all services provided by the Temporary within 12 months of the date this hour verification was signed.
5. It is agreed that the Doctor will be bound by the signature on the front of this verification, whether signed by the Doctor or the Authorized agent, to pay the agency the current agency fee if the Doctor or anyone through his or her directive, employs this agency Temporary within 12 months of the date this verification was signed. The rate charged will be for the position for which this agency temporary was hired.
6. Invoices are net, due upon receipt. Invoices outstanding for more than 30 days will be charged interest of 1.5% per month, computed and billed weekly. In the event this account is referred to collection, the client agrees to be responsible for all court cost, private process fees, and attorney's fees of 25% of the balance due and owing at the time of referral.
7. It is understood and agreed that the client will not entrust any Dental / Medical Associates employee with the care, custody or control of cash, valuables, or other similar property without specific written permission from Dental / Medical Associates, and then only when an employee's specific duties necessitate such activity.
8. The client agrees, that as the utilizing employer, the he / she has full responsibility to insure compliance with all OSHA regulations with respect to providing the following to the Dental / Medical Associates employee.
   - Written Exposure Control Plan
   - Written Hazard Communication Plan
   - All required personal protective equipment and disposal.

I have read the terms and conditions above for this hour verification and placement agreement, and I agree to be bound by them. It is hereby agreed that the hours shown are correct and that the work was performed satisfactory.

CLIENT or AUTHORIZED SIGNATURE: **Date:**