Week Ending: (Saturdays Date)	Employee Name:		
________/________/________ Month Day Year	Last Name	First Name	MI

MUST BE IN BY MONDAY @ 9:00AM
Fax : (513) 605-1320

Client Name (Where you work):	

	TOTAL	Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Straight Time								
Overtime								
TOTAL								

When calculating hours, please round to the nearest quarter hour.

Employee Signature:
By signing this document I attest that all the information is accurate and I have completed all required fields

X____

We understand that the services provided by Aquarius Technology Services are contractual. Therefore, in consideration thereof, we agree that if the employee named herein is employed within 180 days from the last day worked, we will pay liquidated damages to Aquarius Technology Services.

Thank you for using Aquarius Technology Services
RETAIN A COPY FOR YOUR RECORDS

Customer Approval:

X____

Required Fields:
Client Name, Week Ending Date, Name, Total Hours, tomer Approval

REMINDER: DO NOT SUBMIT UNLESS APPROVED BY CLIENT