



**TIMESHEET**

Name:	
Address:	
Email:	
Phone:	
Position:	

	DATE	(AM) IN	(AM) OUT	(PM) IN	(PM) OUT	*OFFICE VERIFY INITIALS
MON						
TUES						
WEDS						
THURS						
FRI						

**DO NOT PAY TEMPORARY; RDTA WILL SEND INVOICE FOR SERVICES**

**FOR OFFICES: \*Please initial hours worked of named temporary.** Please review these hours before initialing. RDTA will not make changes to hours after the timesheet has been received by RDTA. *We agree that the hourly rate and daily placement fee will be paid directly to Rise Dental Temp Agency and acknowledge there is a four (4) hour minimum on all placements. We further agree that scheduling of this temporary will be completed by Rise Dental Temp Agency. In the event that the named temporary is permanently placed within this office in the future, Rise Dental Temp Agency will be paid accordingly. Office will be billed weekly. Payment is due upon receipt of invoice, within 15 days. The individual signing this Timesheet is an authorized representative of the practice and certifies that the hours worked as entered are true and correct.*

Office Name: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Relation to Office: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR TEMPORARY:** Please return completed Timesheet following your placement to [@RiseDentalTemps@gmail.com](mailto:@RiseDentalTemps@gmail.com) or text to 501-622-9755 with Subject: PAYMENT REQUEST: (YOUR NAME). *By signing this Timesheet, I certify that the hours worked as entered are true and correct.*

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_