

ABN 37 003 867 007

Phone: 02 9262 6999

Fax: 02 9262 6607

CLIENT COMPANY NAME:	
WEEK ENDING (FRIDAY):	
MANAGER'S NAME:	

I hereby certify that the hours shown hereon were worked by me during the week ending designated and were certified by an authorised representative of the Client.

EMPLOYEE NAME:	
EMPLOYEE SIGNATURE:	

DAY	DATE	START	FINISH	LESS LUNCH	TOTAL HOURS
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					
			TOTAL WEEKLY HOURS		

CLIENT APPROVAL	
PLEASE CHECK THIS FORM CAREFULLY. Signature indicates verification of hours worked.	
SIGNATURE:	
PRINT NAME:	
DATE:	
POSITION:	