Kavida Healthcare, Inc.
335 Central Street, Saugus, MA 01906
Ph: 781-417-5000 / Fax: 781-417-5002
Email: Timesheet@kavidahealthcare.com
www.kavidahealthcare.com

EMPLOYEE TIME SLIP

Employee Name: _____

Facility Name/Address: _____

Client agrees not to employ the above employee directly or indirectly for a period of one hundred eighty (180) days from their latest assignment this week. If the employee named herein is hired, I agree to pay as liquidated damages to Kavida Healthcare, Inc., upon demand the sum of five thousand ($5,000) dollars for breach of contract.

DAY	DATE	TIME IN	TIME OUT	FLOOR/UNIT	SUPERVISOR NAME	SUPERVISOR SIGNATURE
SUNDAY						
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						

As per the state of Massachusetts guidelines, employees are REQUIRED to take a 30-minute break for shift exceeding six hours. This is an UNPAID break. **It is <u>YOUR responsibility</u>** to ensure that you take your break(s) during your scheduled work hours.

By signing below, I confirm the accuracy of this document in representing my work hours for the current week. The recorded hours have been duly verified by either the client or an authorized representative. I acknowledge that falsifying time slips is a grave violation of Agency policy. I agree NOT to be employed by the client named above for a period of one hundred (180) days following the termination of this assignment. I also confirm that I did not sustain any injuries during this assignment.

EMPLOYEE SIGNATURE: _____

* Time slips must be fully completed for each shift worked. If you work at multiple facilities within a pay week, a separate time slip is required for each location. Non-compliance with this policy may lead to delayed payment. Please submit all time slips by 12 PM on Monday to ensure timely payment. *