Time Sheet

Property:	Employee name:

Timecards ARE DUE Monday Morning 9:30am -NO EXCEPTIONS!!! Anytime received after 9:30am will not be processed until the following week.

Day	Date	Start Time	Lunch Start	Lunch End	Finish Time	Regular Hours	Overtime Hours
Monday							
Tuesday							
Wednesday							
Thursday							
Friday							
Saturday							
Sunday							

Total Hours:	Total Overtime Hours:

Print Name: Date:

Manager Signature:

CLIENT AGREEMENT: I agree and certify that I am authorized to sign this time sheet. I am an authorized agent of the Management Company shown above and the agent of the Owner(s) of this property. Furthermore, I agree that the management Company shown above shall fully compensate MetroPlex Staffing LLC for money's owned pursuant to the terms of this agreement. I certify that any services performed under this agreement are subject to a lien if not paid within 90 days. I understand that any hours worked on this property by MetroPlex Staffing temporary employees in excess of 40 hours per week will be billed to the property at 1.5 times that regular hourly rate. Execution of this agreement by the undersigned client representative constitutes an agreement by the Management Company and Owner(s) of this property to all the terms and provisions stated on this document. I certify the above associate hours are correct. By signing I agree to the hours and no changes can be made. Temporary Employee: I certify that the hours I worked are correct. When my job assignment is complete I agree to notify Metroplex Staffing within 24 hrs my availability for work. If I do not make contact within MetroPlex within 24hrs my unemployment benefits may be denied.

Conditions: Client acknowledges that MetroPlex Staffing has incurred substantial expenses for the recruiting, screening and marketing of the temporary employee named on this card. Client agrees that utilizing or employing the temporary employee submitted by MetroPlex Staffing directly or indirectly at any property owned or managed by the Client within 100 days of Introduction will result in MetroPlex Staffing charging a placement fee of $3,000.00. Client Acknowledges and agrees to pay the placement fee within ten (10) days from the invoice date. Client will not allow any temporary employees of MetroPlex Staffing to operate motor vehicles or machinery or entrust any temporary employees with cash, negotiables or other valuables without the prior written consent of MetroPlex Staffing.. It is acknowledged that the person signing this time card is an authorized representative of the Management Company listed and agrees that all work and services performed on the property listed above were done in a satisfactory manner. All invoices are due within thirty (30) days from the date of the invoice. All past due invoices will be charged a late penalty fee of 5% per month until paid in full. Client and Management Company will jointly and severally be liable for any and all collection fees and or costs including but not limited to court costs and attorneys fees. This agreement is entered into and performable in the State of Texas. In the event enforcement becomes necessary, then venue and jurisdiction shall be with a court in Tarrant County, TX

Date:	

Pay Day Pro
Direct Deposit – Employee Authorization

_____ _____
Company Name **Company Client Code**

_____ _____
Employee Name **Employee Soc Sec No**

I hereby authorize PayDay Pro (hereafter "Company") and the financial institution(s) (hereafter "Bank") listed below to direct deposit my pay automatically to the indicated account(s) and to make adjusting entries including the removal of funds if my employer does not make them available.

I also authorize Company to deposit any amounts owed me by initiating credit entries to my accounts at the Bank(s) indicated on the bottom of this form. Further, I authorize Bank to accept and credit any credit entries indicated by Company to my accounts. In the event that Company deposit funds erroneously into my account, I authorize Company to debit my account for the amount not to exceed the original amount of the erroneous credit.

This authorization is to remain in full force and effect until Company and Bank have received written notice from me of its termination in such time and in such manner as to afford Company and Bank reasonable opportunity to act on it.

Attach a VOIDED CHECK for each checking account. Verify ALL bank information if using a savings account. ONLY completed and signed forms will be processed.
DEPOSIT SLIPS CANNOT BE USED.

A._____
Bank Name/City/State

___ Checking ____ Savings Account no._____ Routing no._____

Deposit$ _____ or _____ Entire Net amount or _____ Remaining Amount

B._____
Bank Name/City/State

___ Checking ____ Savings Account no._____ Routing no._____

Deposit$ _____ or _____ Entire Net amount or _____ Remaining Amount

C. _____
Bank Name/City/State

___ Checking ____ Savings Account no._____ Routing no._____

Deposit$ _____ or _____ Entire Net amount or _____ Remaining Amount

Deposits are normally available on check date between 8:00 am and 12:00 midnight. It is my responsibility to verify deposits on a **pay period basis** before writing checks against these funds. This Authorization can take up to two (2) pay periods to activate. I understand that neither my employer nor **Pay Day Pro** is responsible for bank errors or bank fees. I have read, understood, and agreed to the above information. I may cancel this Direct Deposit(s) at any time by written request. Banking services are provided in accordance with the limitations and restrictions of the National Automated Clearing House Association.

_____ _____
Employee Signature **Date**

WORKWELL,TX

Employee Acknowledgment of Workers' Compensation Network

I have received information that informs me how to get health care under my employer's workers' compensation insurance.

If I am hurt on the job and live in a service area described in this packet, I understand that:

- I must choose a treating doctor from the list of doctors in the network. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor. If I select my HMO primary care physician as my treating doctor, I will call Texas Mutual Insurance Company at (844) 867-2338 to notify them of my choice.
- I must go to my treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me to a specialist. If I need emergency care, I may go anywhere.
- Texas Mutual will pay the treating doctor and other network providers for the treatment for my compensable injury.
- I may have to pay the bill if I get health care from someone other than a network doctor without prior network approval.

Knowingly making a false workers' compensation claim may lead to a criminal investigation that could result in criminal penalties such as fines and imprisonment.

_____ _____ _____

Signature Date Printed name

I live at: _____

Street address

_____

City State Zip code

Name of employer: _____

Name of network: WorkWell, TX

To the employer:

Each employee must sign this form when you begin the program or within 3 days of being hired, and at the time an injury occurs. Please indicate at which point this acknowledgment was completed.

□ Initiating the network program (companywide)
□ Initial employee notification (new hire)
□ Injury notification (Date of injury: / /)

Keep this completed form in the employee's personnel file. It could be requested by Texas Mutual.