

1224 Hammond Drive
 Suite 1500
 Atlanta, GA 30346
 Phone: 404.257.7900
 Fax: 404.257.1070

WEEK ENDING Saturday's date: / / Month Day Year		EMPLOYEE NAME Last Name First Name Middle Initial						
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 information is accurate and I have completed all required fields. X
CUSTOMER APPROVAL X

We understand that the services provided by Insight Global 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 Insight Global.

Thank you for using Insight Global.
Retain a copy for your records.

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

REMINDER: DO NOT SUBMIT, UNLESS APPROVED BY CLIENT