P.O. Box 765, Hershey, PA 17033
(570) 374-8038

DOCTOR'S NAME ______________________

DOCTOR'S ADDRESS ______________________

____

DOCTOR'S PHONE NUMBER ______________________

TYPE OR PRINT YOUR NAME AND ADDRESS ______________________

____

Leave PINK COPY with Temp when signed on Friday or when assignment is completed at end of week
Mail WHITE COPY to Dental Power
Dental Office keep YELLOW COPY

Auxiliary: I certify that the time worked as shown is true and accurate and was worked by me during the days in the indicated week and was properly certified by the dentist or dentist's representative. I further certify that I will not seek or accept employment directly or indirectly from this dentist or his staff without prior notification to Dental Power.

Signature of Temp. ______________________

	DATE/ YEAR	TIME IN	LUNCH OUT	LUNCH IN	TIME OUT	DAILY TOTAL
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						
					Total Hours Less Lunch To Nearest Qtr. Hour	

I have read the terms and conditions on reverse side of this hour verification and I agree to be bound by them. It is hereby agreed that the hours stated above are correct and that the work was performed satisfactorily.

Doctor's Signature ______________________ Date __________

Dental Power
It takes power to make the connection

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