ACCREDITED™ **ACCREDITED NURSING SERVICES**

NURSE'S NAME (PRINT) EMP. NO.

PATIENT'S NAME (PRINT)

REGIONAL CENTER NAME

ENTER DAILY			OFFICE USE ONLY	
DAY/ DATE	IN	OUT	REG. TIME	OVER-TIME
MON.				
TUES.				
WED.				
THURS.				
FRI.				
SAT.				
SUN.				
WEEK ENDING				

I HEREBY CERTIFY TO YOU THAT YOUR ABOVE NAMED EMPLOYEE HAS PERFORMED SATISFACTORY SERVICES FOR US FOR THE TIME INDICATED AND AUTHORIZE YOU TO BILL THE PATIENT AND THE UNDERSIGNED FOR SUCH SERVICES. I UNDERSTAND THAT ACCREDITED NURSING SERVICES IS NOT AN EMPLOYMENT AGENCY AND THAT THE SERVICE IT RENDERS IS MADE POSSIBLE ONLY BY A SUBSTANTIAL INVESTMENT IN ADVERTISING, TESTING AND TRAINING A LARGE STAFF OF PERSONNEL. THEREFORE, IN CONSIDERATION FOR THIS SERVICE BEING MADE AVAILABLE TO US, IN THE EVENT THE ABOVE NAMED EMPLOYEE BECOMES EMPLOYED BY US WITHIN 270 DAYS FROM THIS DATE, I ACKNOWLEDGE IT WOULD BE DIFFICULT TO ASCERTAIN THE PRECISE AMOUNT OF DAMAGES THAT ACCREDITED NURSING SERVICES WOULD SUFFER. THEREFORE, I AGREE THAT I WILL BE OBLIGATED TO PAY ACCREDITED NURSING SERVICES $5,000.00 IN LIQUIDATED DAMAGES.

X _____
NURSE'S SIGNATURE DATE

X _____
CLIENT'S SIGNATURE DATE

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