Dental Temps VT LLC
2 Cody Drive, St Albans, VT 05478
C (8020 370-6732
F (802) 528-5951

Note: Half Day minimum on all assignments (4 hours)
This slip Confirms the referral of ________________ for temporary contract work at your facility. The referral has been screened for appropriate licenses and references. Dental Temps VT will bill the above facility a referral fee at the completion of each assignment. The Dental Facility is responsible for all payments to the referral for all hours worked. The above facility realizes that a referral fee will be charged by Dental Temps VT whenever the above referral is contacted on a temporary basis for the next twelve months. The facility also agrees that is they permanently hire the above referral they will be billed a permanent placement fee.

The signature constitutes acceptance in full of all information on this timesheet.
Signature of Dentist or Authorized Representative

Sign here: ________________________________
Position/Title: _____________________________
Dentist Name: _____________________________

Employee Must Sign this Form

To accept assignments in this office again I understand that prior agreements must be made through Dental Temps VT and directly by me. I furthermore, agree to complete and return the timesheets to the Dental Temps office on a bimonthly basis.

Signature: _________________________________

Temp Name:	DDS Name/Facility
Temp Address:	Facility Address:
City, State, Zip	City, State, Zip

Hyg ☐ Assist. ☐ FD ☐

	Date	Morning Hours	Afternoon Hours
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Weekly Total #Hours	___________________ X_________________________=_______________________		