Dental Temps VT LLC
15 Tanglewood Drive · St. Albans, VT 05478
W (802) 524-2960 C (802) 370-6732

Note: Half day minimum on all assignments (4 hours).

This slip confirms the referral of ______________ for temporary contract work in your facility. The referral has been screened for appropriate Licenses, Hepatitis Vaccine, OSHA training 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 when ever the above referral is contracted on a temporary basis for the next twelve months. The facility also agrees that if they permanently hire the above referral they will be billed a permanent placement fee.

The signature below constitutes acceptance in full of all information on this card.

Signature of Dentist or Authorized Representative

Sign here: ______________________

Position/Title: ______________________

Dentist Name: ______________________

EMPLOYEE MUST SIGN THIS FORM

To accept assignment in this office again I understand that prior agreements must be made through Dental Temps VT and not directly by me. I, furthermore, agree to complete and return the time sheets to the Dental Temps VT office on a bimonthly basis.

Employee Signature: ______________________

Mail white copy to Dental Temps VT 15th and last day of month

Temp. Name		DDS Name/Facility	
Temp. Address		Facility Address	
City, State, Zip		City, State, Zip	
Hyg. ☐	Asst.☐	F.D. ☐	D.D.S. ☐
	Date	Morning Hours	Afternoon Hours
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Weekly Total # hrs. ________ x ________ = ________

Leave yellow copy for dentist

Keep pink copy

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