

**Fill in this information to identify the case:**

Debtor 1 Fayette Memorial Hospital Association  
Debtor 2 \_\_\_\_\_  
(Spouse, if filing)  
United States Bankruptcy Court for the: Southern District of Indiana  
Case number 18-07762

RECEIVED  
FEB 01 2019  
BMC GROUP

Official Form 410

**Proof of Claim**

04/16

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. Do not send original documents; they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) that you received.

**Part 1: Identify the Claim**

1. Who is the current creditor?	<u>Randstad Healthcare</u> Name of the current creditor (the person or entity to be paid for this claim) Other names the creditor used with the debtor <u>Randstad North America, Inc</u>												
2. Has this claim been acquired from someone else?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. From whom? _____												
3. Where should notices and payments to the creditor be sent? Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)	<table border="0"><tr><td><b>Where should notices to the creditor be sent?</b></td><td><b>Where should payments to the creditor be sent? (if different)</b></td></tr><tr><td><u>Randstad North America, Inc</u> Name</td><td>_____ Name</td></tr><tr><td><u>3625 Cumberland Blvd Suite 600</u> Number Street</td><td>_____ Number Street</td></tr><tr><td><u>Atlanta GA 30339</u> City State ZIP Code</td><td>_____ City State ZIP Code</td></tr><tr><td>Contact phone <u>770-937-7000</u></td><td>Contact phone _____</td></tr><tr><td>Contact email _____</td><td>Contact email _____</td></tr></table> <p>Uniform claim identifier for electronic payments in chapter 13 (if you use one): _____</p>	<b>Where should notices to the creditor be sent?</b>	<b>Where should payments to the creditor be sent? (if different)</b>	<u>Randstad North America, Inc</u> Name	_____ Name	<u>3625 Cumberland Blvd Suite 600</u> Number Street	_____ Number Street	<u>Atlanta GA 30339</u> City State ZIP Code	_____ City State ZIP Code	Contact phone <u>770-937-7000</u>	Contact phone _____	Contact email _____	Contact email _____
<b>Where should notices to the creditor be sent?</b>	<b>Where should payments to the creditor be sent? (if different)</b>												
<u>Randstad North America, Inc</u> Name	_____ Name												
<u>3625 Cumberland Blvd Suite 600</u> Number Street	_____ Number Street												
<u>Atlanta GA 30339</u> City State ZIP Code	_____ City State ZIP Code												
Contact phone <u>770-937-7000</u>	Contact phone _____												
Contact email _____	Contact email _____												
4. Does this claim amend one already filed?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Claim number on court claims registry (if known) _____ Filed on _____ MM / DD / YYYY												
5. Do you know if anyone else has filed a proof of claim for this claim?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes. Who made the earlier filing? _____												

**Part 2: Give Information About the Claim as of the Date the Case Was Filed**

6. Do you have any number you use to identify the debtor?  No  
 Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: 7 6 2 7

7. How much is the claim? \$ 79,508.25. Does this amount include interest or other charges?  
 No  
 Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim? Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.  
Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).  
Limit disclosing information that is entitled to privacy, such as health care information.  
Services Performed

9. Is all or part of the claim secured?  No  
 Yes. The claim is secured by a lien on property.  
**Nature of property:**  
 Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim*.  
 Motor vehicle  
 Other. Describe: \_\_\_\_\_  
**Basis for perfection:** \_\_\_\_\_  
Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)  
**Value of property:** \$ \_\_\_\_\_  
**Amount of the claim that is secured:** \$ \_\_\_\_\_  
**Amount of the claim that is unsecured:** \$ \_\_\_\_\_ (The sum of the secured and unsecured amounts should match the amount in line 7.)  
**Amount necessary to cure any default as of the date of the petition:** \$ \_\_\_\_\_  
**Annual Interest Rate** (when case was filed) \_\_\_\_\_ %  
 Fixed  
 Variable

10. Is this claim based on a lease?  No  
 Yes. Amount necessary to cure any default as of the date of the petition. \$ \_\_\_\_\_

11. Is this claim subject to a right of setoff?  No  
 Yes. Identify the property: \_\_\_\_\_

12. Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?

- No  
 Yes. Check one:

A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.

- Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).  
 Up to \$2,850\* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).  
 Wages, salaries, or commissions (up to \$12,850\*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).  
 Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).  
 Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).  
 Other. Specify subsection of 11 U.S.C. § 507(a)( ) that applies.

Amount entitled to priority
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____
\$ _____

\* Amounts are subject to adjustment on 4/01/19 and every 3 years after that for cases begun on or after the date of adjustment.

**Part 3: Sign Below**

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to \$500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

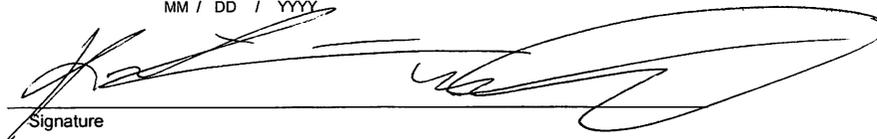
- I am the creditor.  
 I am the creditor's attorney or authorized agent.  
 I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.  
 I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date 11/28/2018  
MM / DD / YYYY

  
 Signature

Print the name of the person who is completing and signing this claim:

Name Ken Wilson  
First name Middle name Last name

Title Sr. Credit Analyst

Company Randstad North America, Inc  
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address 3625 Cumberland Blvd Suite 600  
Number Street

Atlanta GA 30339  
City State ZIP Code

Contact phone 770-937-4637 Email ken.wilson@randstadusa.com



ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Invoice #	Client #	Invoice Date	Page #
801211786	B17627	10/13/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
10/13	MOLLY OBRIEN	26.25	75.00	.00	.00	RN	1968.75
	ON-CALL			13.25	2.00		26.50
SALES TAX :							.00
		26.25		13.25		<b>Total amount due</b>	1,995.25

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801211786	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	1,995.25	



ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Invoice #	Client #	Invoice Date	Page #
801211785	B17627	10/13/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
10/12	MOLLY OBRIEN ON-CALL	13.75	75.00	2.25 39.75	85.00 2.00	RN	1222.50 79.50
SALES TAX :							.00
		13.75		42.00		<b>Total amount due</b>	<b>1,302.00</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801211785	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	1,302.00	



Invoice #	Client #	Invoice Date	Page #
801211459	B17627	10/06/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
10/06	MOLLY OBRIEN	29.75	75.00	.00	.00	RN	2231.25
	ON CALL			15.50	2.00		31.00
SALES TAX :							.00
		29.75		15.50		<b>Total amount due</b>	<b>2,262.25</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801211459	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,262.25	



ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Invoice #	Client #	Invoice Date	Page #
801211118	B17627	09/29/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
09/29	MOLLY OBRIEN ON CALL	40.00	75.00	.00 15.50	.00 2.00	RN	3000.00 31.00
SALES TAX :							.00
		40.00		15.50		<b>Total amount due</b>	3,031.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801211118	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,031.00	



Invoice #	Client #	Invoice Date	Page #
801210779	B17627	09/22/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
09/22	MOLLY OBRIEN ON CALL	40.00	75.00	.00 15.50	.00 2.00	RN	3000.00 31.00
SALES TAX :							.00
		40.00		15.50		<b>Total amount due</b>	3,031.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801210779	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,031.00	



Invoice #	Client #	Invoice Date	Page #
801210473	B17627	09/15/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
09/15	MOLLY OBRIEN ON CALL	40.00	75.00	.50 39.00	85.00 2.00	RN	3042.50 78.00
SALES TAX :							.00
		40.00		39.50		<b>Total amount due</b>	3,120.50

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801210473	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,120.50	



ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Invoice #	Client #	Invoice Date	Page #
801210164	B17627	09/08/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
09/08	MOLLY OBRIEN ON-CALL	16.00	75.00	.00 39.75	.00 2.00	RN	1200.00 79.50
SALES TAX :							.00
		16.00		39.75		<b>Total amount due</b>	1,279.50

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801210164	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	1,279.50	



Invoice #	Client #	Invoice Date	Page #
801209855	B17627	09/01/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
09/01	MOLLY OBRIEN ON-CALL	31.75	75.00	.00	.00	RN	2381.25
				15.50	2.00		31.00
SALES TAX :							.00
		31.75		15.50		<b>Total amount due</b>	2,412.25

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801209855	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,412.25	



Invoice #	Client #	Invoice Date	Page #
801209546	B17627	08/25/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
08/25	MOLLY OBRIEN	37.50	75.00	2.50	75.00	RN	3212.50
	ON CALL			2.50	85.00		105.50
				52.75	2.00		
SALES TAX :							.00
		37.50		57.75		<b>Total amount due</b>	3,318.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801209546	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,318.00	



Invoice #	Client #	Invoice Date	Page #
801208941	B17627	08/11/18	1

ATTN : HAYLEEC@FAYETTEREGIONAL.ORG  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 1941 VIRGINIA AVE  
 CONNERSVILLE, IN 47331

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
08/11	MOLLY OBRIEN	32.00	75.00	.00	.00	RN	2400.00
	ON CALL			15.50	2.00		31.00
						SALES TAX :	.00
		32.00		15.50		<b>Total amount due</b>	<b>2,431.00</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801208941	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,431.00	



Invoice #	Client #	Invoice Date	Page #
801208654	B17627	08/04/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
08/04	MOLLY OBRIEN	37.25	75.00	2.75	75.00	RN	3233.75
	ON CALL			2.75	85.00		73.50
SALES TAX :							.00
		37.25		5.50		<b>Total amount due</b>	<b>3,307.25</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801208654	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,307.25	



Invoice #	Client #	Invoice Date	Page #
801208365	B17627	07/28/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
07/28	MOLLY O'BRIEN	38.75	75.00	.00	.00	RN	2906.25
	ON CALL			55.25	2.00		110.50
SALES TAX :							.00
		38.75		55.25		<b>Total amount due</b>	<b>3,016.75</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801208365	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,016.75	



Invoice #	Client #	Invoice Date	Page #
801208056	B17627	07/21/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
07/21	MOLLY OBRIEN ON CALL	38.75	75.00	.00	.00	RN	2906.25 30.50
SALES TAX :							.00
		38.75		.00		<b>Total amount due</b>	2,936.75

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801208056	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,936.75	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801207734	B17627	07/14/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
07/14	MOLLY OBRIEN	32.00	75.00	.00	.00	RN	2400.00
SALES TAX :							.00
		32.00		.00		<b>Total amount due</b>	2,400.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801207734	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,400.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801207453	B17627	07/07/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
07/07	MOLLY OBRIEN	11.75	75.00	.00	.00	RN	881.25
SALES TAX :							.00
		11.75		.00		<b>Total amount due</b>	881.25

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801207453	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	881.25	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801207181	B17627	06/30/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
06/30	MOLLY OBRIEN ON CALL	39.00	75.00	.00 39.50	.00 2.00	RN	2925.00 79.00
SALES TAX :							.00
		39.00		39.50		<b>Total amount due</b>	<b>3,004.00</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801207181	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,004.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801206899	B17627	06/23/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
06/23	MOLLY OBRIEN ON CALL	40.00	75.00	.00 53.75	.00 2.00	RN	3000.00 107.50
SALES TAX :							.00
		40.00		53.75		<b>Total amount due</b>	<b>3,107.50</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801206899	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,107.50	



Invoice #	Client #	Invoice Date	Page #
801206632	B17627	06/16/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
06/16	MOLLY OBRIEN	36.25	75.00	.00	.00	RN	2718.75
	ON CALL			39.50	2.00		79.00
SALES TAX :							.00
		36.25		39.50		<b>Total amount due</b>	<b>2,797.75</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801206632	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,797.75	



Invoice #	Client #	Invoice Date	Page #
801206375	B17627	06/09/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
06/09	MOLLY OBRIEN	40.00	75.00	.75	85.00	RN	3063.75
	ON CALL			14.75	2.00		29.50
						SALES TAX :	.00
		40.00		15.50		<b>Total amount due</b>	<b>3,093.25</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801206375	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,093.25	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801205851	B17627	05/26/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
05/26	MOLLY OBRIEN ON CALL	32.00	75.00	.00	.00	RN	2400.00 79.00
SALES TAX :							.00
		32.00		.00		<b>Total amount due</b>	<b>2,479.00</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801205851	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,479.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801205606	B17627	05/19/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
05/19	MOLLY OBRIEN ON CALL	39.25	75.00	.00 70.75	.00 2.00	RN	2943.75 141.50
SALES TAX :							.00
		39.25		70.75		<b>Total amount due</b>	<b>3,085.25</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801205606	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,085.25	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801205359	B17627	05/12/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
05/12	MOLLY OBRIEN ON CALL	35.00	75.00	.00 14.00	.00 2.00	RN	2625.00 28.00
SALES TAX :							.00
		35.00		14.00		<b>Total amount due</b>	2,653.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801205359	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,653.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801205097	B17627	05/05/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
05/05	MOLLY OBRIEN ON CALL	40.00	75.00	.00	.00	RN	3000.00 79.00
SALES TAX :							.00
		40.00		.00		<b>Total amount due</b>	<b>3,079.00</b>

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801205097	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,079.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801204836	B17627	04/28/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
04/28	MOLLY OBRIEN ON CALL	40.00	75.00	.25 51.50	85.00 2.00	RN	3021.25 103.00
SALES TAX :							.00
		40.00		51.75		<b>Total amount due</b>	3,124.25

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801204836	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,124.25	



Invoice #	Client #	Invoice Date	Page #
801204586	B17627	04/21/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
04/21	MOLLY OBRIEN ON CALL	33.00	75.00	.00 15.50	.00 2.00	RN	2475.00 31.00
SALES TAX :							.00
		33.00		15.50		<b>Total amount due</b>	2,506.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801204586	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,506.00	



Invoice #	Client #	Invoice Date	Page #
801204318	B17627	04/14/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
04/14	MOLLY OBRIEN ON CALL	40.00	75.00	.00 15.50	.00 2.00	RN	3000.00 31.00
SALES TAX :							.00
		40.00		15.50		<b>Total amount due</b>	3,031.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801204318	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,031.00	



Invoice #	Client #	Invoice Date	Page #
801204047	B17627	04/07/18	1

ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
04/07	MOLLY OBRIEN ON CALL	40.00	75.00	.00 15.50	.00 2.00	RN	3000.00 31.00
SALES TAX :							.00
		40.00		15.50		<b>Total amount due</b>	3,031.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801204047	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,031.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801203761	B17627	03/31/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
03/31	MOLLY OBRIEN ON-CALL	39.00	75.00	.00	.00	RN	2925.00
				24.00	2.00		48.00
SALES TAX :							.00
		39.00		24.00		<b>Total amount due</b>	2,973.00

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801203761	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	2,973.00	



ATTN : ACCOUNTSPAYABLE@FAYETTEREGIONAL  
 MEDEFIS / FAYETTE REGIONAL HEALTH SYST  
 HAYLEEC@FAYETTEREGIONAL.ORG

Invoice #	Client #	Invoice Date	Page #
801203476	B17627	03/24/18	1

Messages:

W/E Date	Employee Name	Regular Hours	Regular Rate	OT Hours	OT Rate	Reference	Amount
03/24	MOLLY OBRIEN ON CALL	40.00	75.00	.00 39.75	.00 2.00	RN	3000.00 79.50
SALES TAX :							.00
		40.00		39.75		<b>Total amount due</b>	3,079.50

This is an invoice for services rendered.  
 - Pay Upon Receipt -

Remittance Copy



Randstad Healthcare  
 13792 Collections Center Drive  
 Chicago, IL 60693  
 1-800-919-9100 - Billing Dept.

Invoice #	Client #	Client Name	Invoice Amount	Amount Enclosed
801203476	B17627	MEDEFIS / FAYETTE REGIONAL HEALTH	3,079.50	