PLAINTIFF CONSENT FORM

I hereby consent to make a claim against SSM Health Care of Wisconsin, Inc. for overtime and regular wage pay. During the past three years, there were weeks that I worked as a nurse for Saint Mary's Hospital during which I was not paid wages, or overtime wages, for certain hours that I worked, including wages for unpaid meal periods.

_____
Signature and Date

_____
Print Name

_____
Address

_____
City, State, Zip Code

_____
Home Telephone

_____
Mobile Telephone

_____
E-Mail Address

_____
Emergency Contact (and phone number)

PLEASE SIGN AND RETURN TO:
HAWKS QUINDEL, SC
222 WEST WASHINGTON AVENUE, SUITE 450
MADISON, WISCONSIN
53703

OR EMAIL/FAX TO:
WPARSONS@HQ-LAW.COM
FAX: (608) 256-0236

QUESTIONS? CALL (608) 257-0040