EMPLOYEE NAME:________________________________ EMPLOYEE ID #:_________ PAY PERIOD ENDING:__________________

DEPT #________________ CONSUMER NAME:____________________________ POSITION:__________________________

RATE: HOURLY SALARY RELIEF OTHER_________________

TYPE: ADMINISTRATIVE FAMILY SUPPORT LINK/SE SUPPORTED LIVING OTHER______________

	WEEKDAY HOURS					WEEKEND HOURS			OVERNIGHTS			OTHER			COMMENTS
DATE	IN	OUT	IN	OUT	TOTAL	IN	OUT	TOTAL	IN	OUT	TOTAL	VAC	SICK	HOL	
1															
2															
3															
4															
5															
6															
7															
8															
9															
10															
11															
12															
13															
14															
15															
TOTALS:															

BY MY SIGNATURE, I CERTIFY THAT THIS TIMECARD IS A TRUE AND ACCURATE ACCOUNT OF HOURS WORKED

REVISED July 15, 2015

EMPLOYEE SIGNATURE:________________________________

SUPERVISOR SIGNATURE: ______________________

FOR FAMILY SUPPORT

PARENT SIGNATURE ________________________________