

EMPLOYEE NAME: _____ EMPLOYEE FILE ID #: _____ PAY PERIOD ENDING: _____

DEPT # _____ CONSUMER NAME: _____ POSITION: _____

RATE: HOURLY SALARY RELIEF OTHER _____

TYPE: ADMINISTRATIVE FAMILY SUPPORT LINK/SE SUPPORTED LIVING OTHER _____

DATE	WEEKDAY HOURS					WEEKEND HOURS			OVERNIGHTS			OTHER			COMMENTS
	IN	OUT	IN	OUT	TOTAL	IN	OUT	TOTAL	IN	OUT	TOTAL	VAC	SICK	HOL	
16															
17															
18															
19															
20															
21															
22															
23															
24															
25															
26															
27															
28															
29															
30															
31															
TOTALS:															

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

REVISED: August 24, 2017

EMPLOYEE

SIGNATURE: _____

SUPERVISOR

SIGNATURE: _____

FOR FAMILY SUPPORT

PARENT

SIGNATURE _____