

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	
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: August 24, 2017

EMPLOYEE

SUPERVISOR

FOR FAMILY SUPPORT

SIGNATURE: _____

SIGNATURE: _____

PARENT

SIGNATURE _____