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	
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 July 15, 2015

EMPLOYEE
SIGNATURE:________________________________

SUPERVISOR
SIGNATURE: ______________________

FOR FAMILY SUPPORT
PARENT
SIGNATURE ______________________________