

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 _____

DATE	WEEKDAY HOURS					WEEKEND HOURS			OVERNIGHTS			OTHER			COMMENTS	
	IN	OUT	IN	OUT	TOTAL	IN	OUT	TOTAL	IN	OUT	TOTAL	VAC	CTSY	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 5/09

EMPLOYEE SIGNATURE: _____

SUPERVISOR SIGNATURE: _____

FOR FAMILY SUPPORT PARENT SIGNATURE _____