

OFFICE OF SCHOOL HEALTH TIME REPORT

Nurses (H-BANK PAYROLL)

SERVICE PERIOD ENDING: ___ / ___ / ___

LAST NAME: _____ FIRST NAME: _____ INITIAL: _____

EMPLOYEE I.D. NO.: _____ TITLE: _____

WORK SCHEDULE: From _____ to _____ LUNCH (30 MIN): From _____ to _____

LOCATION 1: _____ PHONE #: _____ SCHEDULE: SU/ M/ T/ W/ TH/ F/ SA

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DAY	DATE	TIME OF ARRIVAL	TIME OF DEPARTURE	Out of Office - Official Business	Out of Office - Personal Reasons	Total Hours	Charge to Sick Leave	Charge to Vested Annual Leave
				Indicate Hours, Location and Purpose	Indicate Hours and Reason			
SUN								
MON								
TUE								
WED								
THR								
FRI								
SAT								
SUN								
MON								
TUE								
WED								
THR								
FRI								
SAT								

I hereby certify that the above time record is a true and accurate record of my attendance, and that I have been actually present in the performance of my official duties for the period, except as indicated above.

SIGNATURE OF EMPLOYEE: _____ DATE: _____

The signature below confirms that the timesheet has been submitted as required.

SIGNATURE OF SUPERVISOR 1: _____ DATE: _____

SIGNATURE OF SUPERVISOR 2: _____ DATE: _____