Council on Aging, Inc.

NAME: _____ **PAY PERIOD:** _____

Week 1 Sunday - Saturday

Date	Client Initials	Time In	Time Out	Total Hours Hours	Total Hours Minutes	OFFICE USE ONLY
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
				Week One Total Hours		

Week 2 Sunday - Saturday

Date	Client Initials	Time In	Time Out	Total Hours Hours	Total Hours Minutes	OFFICE USE ONLY
Sunday						
Monday						
Tuesday						
Wednesday						
Thursday						
Friday						
Saturday						
				Week Two Total Hours		

PAID CK# | TITLE | DATE | AMOUNT

TOTAL HOURS:

PERSONAL CARE **WAIVER** **TBI** **PRIVATE** **TRAINING**

FAIR **RESPITE** **LIGHTHOUSE** **VACATION**

I CERTIFY THAT THE REPORTED INFORMATION IS CORRECT

EMPLOYEE SIGNATURE: _____ **DATE:** _____ **GRAND TOTAL** _____

SUPERVISOR SIGNATURE: _____ **DATE:** _____