DISABILITY SERVICES
TIME SHEET

JOB TITLE *(Check One)*

Interpreter _____ Reader/Scribe_____   **MONTH**: _____
Mobility _____ Tutor _____
Note taker _____ Typist _____Pay Period: 1st - 15th:_____*(Check One)*
Note/Typist _____ Lab Asst _____   16th - 31st:_____
Other _____

EMPLOYEE

Name: _____   *(DATE STAMP)*

CID: _____

Telephone: _____

Student: _____ Non-Student:_____*(Check One)*

CLIENT NAME: _____

DAYS OF MONTH	HOURS WORKED	DAYS OF MONTH	HOURS WORKED	DAYS OF MONTH	HOURS WORKED
1ST		12TH		23RD	
2ND		13TH		24TH	
3RD		14TH		25TH	
4TH		15TH		26TH	
5TH		16TH		27TH	
6TH		17TH		28TH	
7TH		18TH		29TH	
8TH		19TH		30TH	
9TH		20TH		31ST	
10TH		21ST			
11TH		22ND			

TOTAL HOURS FOR 2-WEEK PAY-PERIOD: _____

_____
Employee Signature / Date

_____
Client Signature / Date

(Do Not Fill In - Office Use Only)

_____
Asst Director/Coordinator / Date

Pay Period: _____

Service/Pos.#: _____/_____

Hrs.@Pay Rate=: _____@_____=_____