

Site: _____

Project Managers: _____

Date: _____

EMPLOYEE NAME <i>(LAST NAME, FIRST NAME)</i>	EMPLOYEE TYPE <i>(FT/PT/VOL/ AGENCY)</i>	AGENCY NAME (if applicable)	EMPLOYEE ID <i>(LIFE NUMBER or ORACLE ID)</i>	HOME DEPARTMENT	POSITION TITLE	TIME IN	TIME OUT	REG HOURS	OT HOURS	PATIENT FACING? <i>(Y/N)</i>	DESCRIPTION OF WORK PERFORMED <i>(Vaccinator, Patient Registration, Administration, etc.)</i>	EMPLOYEE SIGNATURE*

**SUPERVISOR SIGNATURE: _____

*I CERTIFY THAT I HAVE WORKED THESE HOURS AND THESE ARE TRUE EXPENSES RELATING TO THE DISASTER EVENT
 **I CERTIFY THAT THESE HOURS ARE AN ACCURATE REFLECTION OF TIME WORKED ON THE DAY INDICATED AT THE TOP OF THIS SHEET. IF THERE IS ANY DISAGREEMENT I AM AT LIBERTY TO DISCLOSE ANY CONCERNS