SYSTEMS ASSESSMENT & RESEARCH, INC.

Name:

Employee ID:

SEMI-MONTHLY TIME SHEET

Period Ending:

MONTH _____

Control # ERR

Contract Name / Billable	Job No.	Task No.	Suffix No.	Lab Code	Description	Pay Type	HOURS															Grand Total
WRAMC PSYCHIATRY Clinical Psychiatrist	4100	032	41	C4	WEEKDAY REGULAR	R																
WRAMC PSYCHIATRY Adult Psychiatrist	4100	032	41	S4	WEEKDAY REGULAR	R																
WRAMC PSYCHIATRY Adult Psychiatrist	4100	032	41	A4	WEEKDAY REGULAR	R																
PAID TIME OFF (PTO)	0220	000	00		LEAVE	V																
HOLIDAY	0305	000	00		LEAVE	R																
JURY DUTY	0307	000	00		LEAVE	R																
MILITARY	0307	000	00		LEAVE	R																
BEREAVEMENT	0308	000	00		LEAVE	R																
OTHER LEAVE	0309	000	00		LEAVE	R																
LEAVE WITHOUT PAY (LWOP)	0310	000	00		LEAVE	L																
					Total Hours																	

Employee's Signature:

Supervisor's Name and Signature:

FAX TO: 301-731-4303 OR 301-731-4344

ATTENTION: HUMAN RESOURCES OR ACCOUNTING