

SYSTEMS ASSESSMENT & RESEARCH, INC.

Name: LAST NAME, FIRST NAME

Employee ID:

**SEMI-MONTHLY TIME SHEET**

Period Ending:

MONTH \_\_\_\_\_

Control # **ERR**

Contract Name	Job No.	Task No.	Suffix No.	Lab Code	Description	Pay Type	HOURS												Grand Total					
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N1	RN II - Day	R																		
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N2	RN II - Holiday Day	H																		
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N3	RN II - Holiday ENW	H																		
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N4	RN II - WEEKEND EVENING	R																		
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N4	RN II - WEEKEND DAY	R																		
DC DEPT YOUTH REHAB SVCS (RN)	4500	300	45	N4	RN II - WEEKDAY EVENING	R																		
<b>TOTAL HOURS</b>																								

Employee's Signature: \_\_\_\_\_

Supervisor's Name and Signature: \_\_\_\_\_

FAX TO: 301-731-4303 OR 301-731-4344  
 ATTENTION: HUMAN RESOURCES OR ACCOUNTING