SYSTEMS ASSESSMENT & RESEARCH, INC.

NAME:

Employee ID:

SEMI-MONTHLY TIME SHEET

Period Ending:

MONTH _____

Control # ERR

							HOURS																
Contract Name	Job	Task	Suffix	Lab		Pay																	Grand
Billable	No.	No.	No.	Code	Description	Type																	Total
CSOSA, EXPRESS THERAPY SVCS	4800	001	45	ET	WEEKDAY REGULAR	R																	
CSOSA, EXPRESS THERAPY SVCS	4800	001	45	E2	IDT MTGS																		
CSOSA, EXPRESS THERAPY SVCS	4800	001	45	E3	PRE SVC TRNG																		
				Total Hours	TOTAL HOURS																		

Employee's Signature:

Supervisor's Name and Signature:

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

ATTENTION: HUMAN RESOURCES OR ACCOUNTING