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
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N1	RN DAY CIVIL	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N1	RN WKEND DAY CIVIL	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N2	RN DAY FOREN	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N2	RN WKEND DAY FOREN	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N3	RN DAY HOLIDAY CIVIL	H																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N4	RN DAY HOLIDAY FOREN	H																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N5	RN WEEKDAY EVE CIVIL	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N5	RN WEEKDAY NIGHT CIVIL	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N5	RN WKEND EVE/NIGHT CIVIL	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N6	RN WEEKDAY EVE FOREN	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N6	RN WEEKDAY NIGHT FOREN	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N6	RN WKEND EVE/NIGHT FOREN	R																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N7	RN EVE/NIGHT HOLIDAY CIVIL	H																	
ST. ELIZ DEPT OF MNTL HEALTH (RN)	4500	400	45	N8	RN EVE/NIGHT HOLIDAY FOREN	H																	
					Total Hours																		

Employee's Signature:

Supervisor's Name and Signature:

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

ATTENTION: HUMAN RESOURCES OR ACCOUNTING