Self Determination Employee Time Card

CT Financial Services

AGENCY

PERSON RECEIVING SERVICE

7720339168

PERIOD BEGIN MM / DD / YY

PERIOD END MM / DD / YY

EMPLOYEE FIRST NAME

EMPLOYEE LAST NAME

Employee Last 4 Digits of your SSN

Month	Day	Service Code	Time In hh:mm	AM(A) PM(P)	Time Out hh:mm	AM(A) PM(P)	Hours Worked	Tasks
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I certify that I worked the hours shown on this card on the days indicated and that this card has been certified by a person that I believe is an authorized representative of/or the person receiving service.

Employee Signature: _____ Date ___/___/___

Total Hours ___.___

As the person receiving service or authorized representative, I certify that this employee's hours shown on this time sheet are correct and that the work was performed satisfactorily.

Supervisor Signature: _____ Date ___/___/___