

Email to: payroll@MyMRCI.org

Fax to: 1-888-800-7336

CDCS & CSG
MRCI-CDS Time-Sheet



Employee's Name: _____

Client's Name: _____

Client Representative: _____

2-Week Pay Period: Sun: _____ Sat: _____
(mm/dd/year) (mm/dd/year)

Was the Client **hospitalized** during this pay period? Yes No

If yes, dates hospitalized: _____ **Time of Day** Client admitted to hospital: _____

Date	From	To	Total Hours
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____
_____	_____ am/pm	_____ am/pm	_____

Hourly Rate: \$ _____ Totals for the pay period: _____
The hours recorded above are accurate and complete for the period indicated

Signature of Employee

Signature of Client/Representative

Date

Date

Not valid unless signed by both Parties

****If hours exceed 40 in a calendar week (Sunday thru Saturday), the resulting overtime may be reportable to the County****