Night Supervision

Prefer Email to: Payroll@MyMRCI.org
Or fax toll free using 1-888-800-7336

MRCI-CDS Time Sheet
Please PRINT using black ink

Employee's Name: _____

Client's Name: _____

Client Representative: _____ Daytime Phone # _____

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

Date	FROM	Hours	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	_____

Hourly rate: $ _____ **Total hours for the pay period**_____

Has the Client been in the Hospital, a Care Facility or Incarcerated during these two weeks?
If so, please complete the following: Date in_____ **Date out**_____

Acknowledgement and Required Signatures (not valid unless signed by both Parties):

Review the completed time sheet for accuracy before signing. **It is a federal crime to provide false information on this timesheet**. Your signature verifies the time and services entered above are accurate. *Night supervision is an awake service and workers are to provide active care continuously.

_____ _____ _____ _____
Employee Signature **Date** **Client/Client Rep** **Date**