Fax Toll Free using: 888-800-7336
Email to: Payroll@MyMRCI.org

Payroll Model
MRCI-CDS Time Sheet
Please PRINT using black ink

Employee's Name: _____

Client's Name: _____ County _____

Client Representative: _____ Daytime Phone # _____

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	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	_____
_____	_____	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

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

FOR OFFICE USE ONLY: Total wages = _____

P.P.E. _____   ___% of TW = _____

___ Spreadsheet   Total =

12/14/16