If faxing, please do not mail **Please PRINT using black ink**

MRCI Time Sheet

Employee's Name _____

Consumer's Name _____

Pay Period 1 - 15 or 16 - Last day of month
(Please circle appropriate pay period)

Was the Consumer **hospitalized** during this pay period? Yes No
If yes, date entered_____
Date released_____
You cannot bill for any hours in any day that the Consumer is hospitalized

Month_____ Year_____
(Only one month per time sheet)

Date	Hours		Total Hours
	From	To	
	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	

Totals for the pay period _____

The hours recorded above are accurate and complete for the period indicated.

_____ _____
Signature of Employee Signature of Consumer/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