

Department: _____

Week Ending: _____

Classified Staff Attendance Report

Salem State College

Last name, first name Emplid Rcd#	Init	TRC/HRS	Day	Time		Meal Break		Time		Overtime		SUPERVISOR INITIALS
				In	Out	In	Out	In	Out	In	Out	OT or Com Voluntary*
Remarks:			S									
			M									
			T									
			W									
			TH									
			F									
			S									
Remarks:			S									
			M									
			T									
			W									
			TH									
			F									
			S									
Remarks:			S									
			M									
			T									
			W									
			TH									
			F									
			S									

*Supervisor must initial if overtime or compensatory time is voluntary.

I certify that this time schedule is a true record of time worked by the employees assigned to this area.

Supervisor: _____
(Signature) (Date)