CO CDASS Program Timesheet

FAX: PPL @ 1-866-741-2718

Member: (Last Name, First Name) _____ Member ID: _____

Employee: (Last Name, First Name) _____ Employee ID: _____

PAY PERIOD: ○ 1st ○ 2nd

Month: _____

Year: 2 0 _____

Service Types: **1/Blank** CDASS - Standard **2** CDASS - Emergency **3** CDASS - Other **4** HMK-LRP **5** Sick Leave

Day of Month	Service Type	Time In (HH:MM)	Time Out (HH:MM)	Total Hours (HH:MM)
		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	

I certify and affirm that this timesheet is an accurate representation of services rendered by the named employee to the named supervisor. Misrepresentation or false statements may result in administrative penalties, criminal prosecution and/or termination from the CDASS program.

Employee Signature: _____ Supervisor/AR Signature: _____

Date: ___ / ___ / 2 0 ___ Date: ___ / ___ / 2 0 ___

*** USE BLACK INK, PRINT ONE CHARACTER PER BOX, TRY NOT TO TOUCH THE LINES!!!**

CORRECT → 1 2 0 1 2 9

INCORRECT → 3 0 2 4 2 9

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