PAFFORD
EMERGENCY MEDICAL SERVICES

TIME CARD CORRECTION FORM

Employee Name:_____

Pay Period:_____

Date of Correction:_____ Station:_____

Clock In:_____Clock Out:_____ Total Hours:_____

Reason for Correction:_____

Date of Correction:_____ Station:_____

Clock In:_____Clock Out:_____ Total Hours:_____

Reason for Correction:_____

Date of Correction:_____ Station:_____

Clock In:_____Clock Out:_____ Total Hours:_____

Reason for Correction:_____

By signing this document, you agree that the information provided above is true and accurate. You also agree that these corrections will not take effect until the pay period following the submission of this form. It is your responsibility to make sure you are clocking in and clocking out each shift and to approve your time card each week. Multiple occurrences will result in disciplinary measures.

Signed by Employee:_____ Date:_____

Approved by Supervisor:_____