

ALLIANCE HEALTH CARE 245B - Supported Living Services

Mailing Address: 2260 Cliff Road
Eagan, MN 55122

Group Home: _____

Employee Name: _____

DAY	2005 DATE	TIME IN	TIME OUT	TOTAL HOURS	EXPLANATION (if needed)	VACATION	PERSONAL
SUN					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
MON					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
TUE					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
WED					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
THU					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
FRI					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		
SAT					_____ Hrs. Admin _____ Hrs. Trng _____ Hrs. D.C		

Weekly Total _____

Employee Signature _____ Date _____

House Coord. Signature _____ Date _____

SPM Signature _____ Date _____

<u>AHS</u>
Regular =
OT=
Vacation=
PTO=
Holiday=

MINIMUM WAGE	
AHC	AHS

<u>AHC</u>
Regular =
OT=
Vacation=
PTO=
Holiday=