



CARE ONE INC.
EMPLOYEE TIME SLIP

Send To:
 Fax: 734-480-9060
 Email: kathyw@careoneinc.com
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 MDOC Facility

 Employee Name (Print)

 Position / Title

 Two Week Pay Period

Date	Day	Start Time	End Time	Daily Meals		Total Time
Week 1	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					
Week 2				Total Hours Week 1		
	Sunday					
	Monday					
	Tuesday					
	Wednesday					
	Thursday					
	Friday					
	Saturday					
Employee Signature				Total Hours Week 2		
				Total Pay Period		

Your signature above indicates these hours are complete and reflect the hours actually worked.

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