ACSD

ASSISTANCE FOR CHILDREN WITH SEVERE DISABILITIES
TIMEHSEET
FAX: 519-972-8902

Support Worker Name: _____ **Pay End Date:** _____

Client Name: _____

Family Coordinator: _____

Dates Worked	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT
Hours Worked Each Day														

TOTAL HOURS TO BE PAID: _____

I hereby certify that the above hours were worked by me in accordance with the contract provisions.

TIMESHEETS ARE NOW DUE EVERY OTHER WEDNESDAY BY 4:00PM

_____

(Signature of Support Worker) **(Date)**

_____

(Approved by Family Respite Services) **(Date)**

_____

(Signature of Parent/ Legal Guardian of Client) **(Date)**

Please Note: The parent or guardian must sign this form in order that the worker be paid.