

COMPENSATORY / OVERTIME WORK APPROVAL AND REPORTING FORM

This form shall be filled out in accordance with provisions outlined in Board Policy File: GCRD
The **original** is to be submitted to the business office. Copies should be retained by the employee and supervisor.

PAY PERIOD: _____ TO _____
BEGINNING DATE ENDING DATE

NAME: _____ DATE: _____

POSITION: _____ WORK SITE: _____

REASON FOR EXTENDED DAY OR NATURE OF EMERGENCY:

ANTICIPATED AMT OF TIME NEEDED: _____

DATE(S) WORK WAS PERFORMED:

DATE	AMT TIME	DATE	AMT TIME
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ACTUAL AMT OT WORKED: _____

EARNED COMPENSATORY TIME IN HOURS: _____

DATE(S) COMPENSATORY TIME USED BY EMPLOYEE:

DATE(S): _____	AMT TIME USED: _____
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the services were performed as stated above.

SIGNATURE OF EMPLOYEE

SIGNATURE OF SUPERVISOR

TO BE COMPLETED BY BUSINESS OFFICE FOR OVERTIME PAY

_____	_____
RATE PER HOUR	GROSS PAY
_____	_____
HOURS WORKED	GROSS PAY

APPROVED DENIED

SIGNATURE OF SUPERINTENDENT/DESIGNEE