

AGENCY EMPLOYEE TIMEKEEPING CORRECTION FORM
FOR (HDO NAME)

NOTICE: The employee should only complete this form if

- (1) The employee missed a clock-in or clock-out
- (2) Unable to take a lunch

Employee Name: _____

Agency: _____

Branch: _____

Unit Manager/Supervisor: _____

Check one: Date

_____ Missing Clock-In Time Actual work start time: _____ a.m.
p.m.

_____ Missing Clock-Out Time Actual work end time: _____ a.m.
p.m.

_____ No Lunch Taken Time _____ mins.

_____ Late Clock-Out Time Punched _____ a.m. Actual work End Time _____ a.m.
p.m. p.m.

Reason/Comments:

Employee Certification:

The times listed above are an accurate statement of actual time worked. All above adjustments must have an explanation to be paid. **Must be signed by manager or supervisor to be paid.**

Employee Signature Date

Manager's Signature Date

ANS/ HAM / Nurse Manager (if applicable) Date

This form must be completed for every instance where the clocked time is changed or needs to be edited in Shiftwise. Please leave a copy of the signed form with the department manager. **Keep a copy for your records.** Please call your agency if you have any questions. Thank you.