



M A T C

PART TIME FACULTY HOURLY TIME REPORT

DENTAL

NAME: _____ *EMPLOYEE SIGNATURE: _____

SOCIAL SECURITY #: _____ *SUPERVISOR SIGNATURE: _____

PAY PERIOD: _____ SUPERVISOR: _____

POSITION NUMBER _____ * Authorization & Approval for pay of time indicated.
 (TIME REPORT WILL NOT BE PROCESSED WITHOUT A POSITION NUMBER)

															TOTAL
	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	
HOURS															
SICK LEAVE															
PROFESSIONAL LEAVE															
OTHER															
CODE FOR OTHER															

															TOTAL
	SUN	MON	TUE	WED	THU	FRI	SAT	SUN	MON	TUE	WED	THU	FRI	SAT	
HOURS															
SICK LEAVE															
PROFESSIONAL LEAVE															
OTHER															
CODE FOR OTHER															

TOTAL HOURS THIS PAY PERIOD _____

OTHER LEAVE CODES

DD - DUTY INCURRED DISABILITY
 MP - MATERNITY DISABILITY LEAVE
 NP - LEAVE NO PAY

JD - JURY DUTY
 ML - MILITARY LEAVE
 O - OTHER (SPECIFY) _____

INSTRUCTIONS

In the space provided, indicate your position number. Indicate below the appropriate day and on the appropriate line, the clock hours you worked or were absent.

At the end of the pay period, total the hours you worked, sign the time report and submit it to your supervisor.