WEEKEND BONUS TIME CORRECTIONS SUBMITTAL RECEIPT

DISCLAIMER: I understand that it is my responsibility to ensure my requests for time corrections are submitted to my manager/nurse manager. The manager will in turn assist in the delivery of the received package(s) to Access to Care Bureau. The manager is not responsible for any delay, late or missing documents. I also understand that Access to Care Bureau will facilitate the delivery of my submitted package(s) to Employee Relations (ER).

I acknowledge the aforementioned disclaimer.								
Print Name	Employee #							
Signature		Date						
I am in receipt of Bureau.		time correction	packages	s that will be delivered to Access to Care				
Manager Name		Title		Employee No.				
Manager Signatu	re	Date						

PLEASE NOTE ACTION REQUIRED:

- Original completed receipt to be retained by Employee/Grievant.
- Employee/Grievant to scan and email a copy of this fully completed receipt to Employee Relations employeerelations@lasd.org.
- Upon receipt of the submitted package(s), Employee Relations will send an email to employee confirming its receipt.

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WEEKEND BONUS/DIFFERENTIAL (PAYROLL CODE 539) CLAIM

LAST NAME	
FIRST NAME	
EMPLOYEE NO.	

DATE WORKED (MM/DD/YY)	SHIFT WORKED (CIRCLE ONE)	TOTAL HOURS WORKED	TOTAL HOURS SHIFT DIFFERENTIAL WAS NOT PAID	COMMENTS
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
	EM AM PM			
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TOTALS				

By signing this claim, I certify that I have carefully reviewed my PHRQ and that the hours reported on this claim are accurate. I understand that the Los Angeles County Fiscal Manual Section 3.1.7 indicates that falsification of timesheet documents by employees may result in disciplinary action, up to and including discharge from County service.