NEW YORK CITY HEALTH + HOSPITALS
TIME RECORD CHANGE FORM

LAST NAME: _____ **FIRST NAME:** _____ **EMPLOYEE ID:** _____

FACILITY: _____ **DISTRIBUTION CODE:** _____

TO CHANGE START AND END TIMES PLEASE COMPLETE THIS SECTION

NEW START TIME: _____ NEW END TIME: _____ EFFECTIVE DATE: _____

DATE SUMMARY WEEK _____	IN	OUT	TIME REPORTING CODE 1	TIME REPORTING CODE 2	REIMBURSEMENT CODE
SUNDAY _____					
MONDAY _____					
TUESDAY _____					
WEDNESDAY _____					
THURSDAY _____					
FRIDAY _____					
SATURDAY _____					

EMPLOYEE SIGNATURE _____

MANAGER OR AUTHORIZED DELEGATE SIGNATURE: _____

RESET