

CONSUMER NAME: _____

EMPLOYEE _____

COUNTY: _____

Additional
In this column, record interrupted sleep time that you worked.

Week 1		Time In	Time Out	Time In	Time Out	Total
Day	Date	am/pm	am/pm	am/pm	am/pm	Hours
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Total Hours Week 1						

<i>For use with 24 Hour Respite Care Only</i>				
Sleep Time		*Additional*		Total
Start	End	Start	End	Hours
Total Hours Week 1				

Week 2		Time In	Time Out	Time In	Time Out	Total
Day	Date	am/pm	am/pm	am/pm	am/pm	Hours
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Total Hours Week 2						

Sleep Time		*Additional*		Total
Start	End	Start	End	Hours
Total Hours Week 2				

Week 3		Time In	Time Out	Time In	Time Out	Total
Day	Date	am/pm	am/pm	am/pm	am/pm	Hours
Sun						
Mon						
Tue						
Wed						
Thu						
Fri						
Sat						
Total Hours Week 3						

Sleep Time		*Additional*		Total
Start	End	Start	End	Hours
Total Hours Week 3				

Pay Period Total

Pay Period Total

Employee Signature

Date

Common Law Employer Signature

Mail To: Orion ISO, Inc.
9400 Golden Valley Road
Golden Valley, MN 55427

Fax or Email To:
Fax Toll Free: 877-677-3314
Fax: 763-450-5027

Common Law Employer Phone #

Phone Toll Free: 877-656-7466 ext.1108
Phone: 763-450-5195

Email: payroll @orionassoc.net