

AMENTUM EMP # _____

TIMESHEET DATE: _____

LOCATION: CDF

NAME: _____

IF CORRECTION TIMESHEET,
ORIGINAL TIMESHEET DATE: _____

CHECK IF APPLICABLE: _____ DISTRIBUTION CORRECTION
(TOTAL HRS. MUST BE ZERO)

_____ PAYROLL CORRECTION

DAY OF THE WEEK	DATE	INCIDENT #	FLIGHT TIME		EXT STANDBY	ACTUAL HOURS/REMARKS
			HOURS	100TH'S		
TOTAL						

ACCOUNT		SAT	SUN	MON	TUES	WED	THURS	FRI	WEEK TOTALS
PA	PAY TYPE	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	HOURS	
CD9009	R								
CD9009	FB4								
	DAILY TOTALS								

I HEREBY MAKE CLAIMS FOR PAYMENT FOR THE TIME WORKED AS INDICATED BY THE HOURS AND EXPENSES SHOWN ON THIS FORM AND I CERTIFY THAT THE INFORMATION CONTAINED HEREON IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE

APPROVAL