

SAMPLE

Page _____ of _____

Month/Year _____

~~AFTER HOURS PHYSICIAN CONSULTATION LOG~~

Employee Name: _____ Bureau: _____ Office: _____ P/L: _____

Employee No.: _____ Payroll Title: _____ Work Phone No.: _____

Supervisor's Name: _____ Work Phone No.: _____

[illegible]

I certify that the information entered above is true and correct. I understand that falsification or misrepresentation on this form may result in disciplinary action including discharge.

Employee Signature

Date

I have verified the information reported on this form. It is true and correct to the best of my knowledge and belief. In signing this form and the employee's timecard, I understand that I am authorizing payment of County funds in accordance with Departmental policy.

Supervisor's Signature

Date _____

Complete in Duplicate

Retain original for 3 years
in office payroll files

Copy for employee