Month/Year:

## WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES Division of Family Assistance Participant Time Sheet

Participants Name:				Site Supervisor's Name:
PIN No.:				Site Supervisor's Phone No.:
Work/Training Site:				WP Activity Code: Contract No.:
3				
Month/Day	Work/Traiı Hours/Min		Reason for Absence	TO BE COMPLETED BY THE PARTICIPANT'S SUPERVISOR
				Work/Study Habits: Good Satisfactory Needs Improvement
				Supervisor's Comments:
				TO BE COMPLETED BY THE PARTICIPANT
				□ I agree □ I disagree with the evaluation of my performance.
				Participant's Comments:
				i ancipant s comments.
				<b>Certification:</b> I certify that the information on this form is correct to the best
				of my knowledge and the statements are made in good faith. I know that
				federal funds are involved and penalties are prescribed by law for willful
				misrepresentation of facts in order to obtain payments or services.
				Participant's Signature:
				Site Supervisor's Signature:
				DHHR STAFF USE ONLY
				Actual Attendance Hours: (Paid Hours for Employment)
				+ Excused Absence Hours: # Days Excused
				+ Federal Holiday Hours: Absences Used YTD
				= Total Monthly Hours: = Weekly Average Hours
				Transportation Payment : # Days X \$ Per Day = \$
				Additional Notes:
TOTAL				

This time sheet must be submitted to the local DHHR office by the 5<sup>th</sup> day of the next month.