MISSISSIPPI STATE DEPARTMENT OF HEALTH

Office of Human Resources

CLASSIFICATION AND COMPENSATION

Report on Compensatory Time/Overtime Earned

Name: _____ **SSN:** _____

Classification:

Status: Exempt (E) or Non-Exempt (N):

Month	**PIN:** _____	**Org:** _____	**Year**

Indicate dates and total time earned.

Partial hours should be rounded to the nearest quarter hour:

Date	**Total**
	hrs.
	hrs.
	hrs.
	hrs.
	hrs.
	hrs.

Total Earned

Employee Signature: _____ Date: _____

Supervisor: _____ Date: _____

Remarks: _____

_____

_____