Lincoln Area Agency on Aging Senior Companion Program

Volunteer Name:_____

Date	Client Name	Work & Inservice Hrs	Vac Hrs	Sick Hrs	Pers Day 4/8 Hrs Each	Holiday 4/8 Hrs Each	Personal Weather Hours or Comments	TOTAL HOURS	Mileage or Other Transp	Meals $1.50	In-Kind Meals

Please continue and sign on reverse side.

Date	Client Name	Work & Inservice Hrs	Vac Hrs	Sick Hrs	Pers Day 4/8 Hrs Each	Holiday 4/8 Hrs Each	Personal Weather Hours or Comments	TOTAL HOURS	Mileage or Other Transp	Meals $1.50	In-Kind Meals
Totals	--------- *Office Use Only* ----------										

I certify that this statement about the hours worked and the amount claimed for mileage is true, correct and complete to the best of my knowledge. If I claimed mileage, I also certify that I possessed a valid driver's license and that liability insurance in the minimum amount required by law was in force at the time of my travel.

Certifications: _____

SCP Volunteer Signature

_____ _____

SCP Volunteer Station Coordinator Signature SCP Staff Signature

MAIL TIMESHEETS ON OR BEFORE
Remember your signature & your Station Supervisor's signature are required.

MARK YOUR CALENDARS!

Office Use Only	Totals
Work, Inservice Hrs	
Vac Hrs	
Sick Hrs	
Pers Day Hrs	
Holiday Hrs	
Pers. Weath. Hrs	
Total Hours	
x $2.65 =	
Total Mileage	
x $.40 =	
Other Trans	
Meals	