Seaford School District
1600 Washington Avenue
Seaford, New York 11783

CLAIM FOR PAYMENT

Employee Name: _____ Week Ending: _____

Social Security Number: _____ Status: _____

Building: High School Supervisor: Michael Ragon

SPECIFIC TYPE OF SERVICE PERFORMED: _____

_____

_____

Day of Week	Date	Start Time	End Time	Total Hours
Tuesday				
Wednesday				
Thursday				
Friday				
Monday				

WEEKLY TOTALS

Employee Signature: _____ Date: _____

Activity Director's Signature: _____ Date: _____

Principal's Approval: _____ Date: _____

Business Office Approval: _____ Date: _____

Paid On: _____ Date: _____

COPY OF THIS FORM MUST BE SUBMITTED WITH THE MONTHLY REPORT

9/01