



DEPARTMENT OF NURSING SERVICES

Bi-WEEKLY OVERTIME RECORD FORM

NYSID#: N				Payroll Pay Period: ____/____/____ THRU ____/____/____			
Employee Name		Title		Regular Tour		Employee	
	Print						Signature

Overtime Date	Home Unit	Overtime Unit	Overtime From		Overtime To		OT Hours Worked	Reason *	Approved by		Verified by		
			Date	Time	Date	Time			PRINT	SIGN	PRINT	SIGN	
TOTAL # OVERTIME WORKED:								COMP TIME:			PAID O/T TOTAL HOURS		

***Reason for OVERTIME: 1 = High Acuity or Assignment Completion 2 = OT One-to-One Assignment 3 = OT No Lunch Break 4 = OT Staff Meeting 5 = OT Supplemental Staffing 6= OT Training 7 = OT Relief 8 = OT Misc. or Other**

NOTE: THE OVERTIME RECORD FORM MUST ACCOMPANY THE EMPLOYEE'S TIMESHEET DURING THE RESPECTIVE PAYROLL PERIOD