

## WEEKLY REPORT OF REDUCED-SCHEDULE WAGES

Report Date: \_\_\_\_\_

Employee Name: \_\_\_\_\_

Department Name: \_\_\_\_\_

Payroll Contact Name: \_\_\_\_\_

Payroll Contact Phone: \_\_\_\_\_

Hours Worked for the week of: \_\_\_\_\_  
(Specify Date Range)

Report only Hours Worked.  
 Do not include Sick, Vacation, or Holiday Leave.

DAY OF WEEK	DATE	HOURS WORKED (a)	HOURLY WAGE (b)	TOTAL WAGES (a)*(b)
MONDAY:				
TUESDAY:				
WEDNESDAY:				
THURSDAY:				
FRIDAY:				
SATURDAY:				
SUNDAY:				
<b>TOTALS:</b>				

Payroll Contact Signature:  
 \_\_\_\_\_

**Fax** in advance, then send this report each week to:

Sedgwick CMS  
 P.O. Box 2063  
 Oakland, CA 94604

Fax: 510-302-3277  
 Tel: 510-302-3180