

OVERTIME FORM

					HRD DEPARTMENT	
EMPLOYEE NAME:			DATE FIL	ED:		
POSITION:			ACCOUN	IT:	1	
DEPARTMENT:		DATE OF OT RENDERED:	TIME START:	TIME END:	TOTAL NO OF HOURS:	
REASON:						
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ENDORSED BY:		RECOMMENDED BY:		APPROVED BY:		
Approved	Disapproved	Approved	Disapproved	Approved	○ Disapproved	
		_		KATHI FF	N REYES, MHM, DBA	
Immediate Superior (Signature over Printed Name)		Department Director (Signature over Printed Name)		Chief Operating Officer		
DATE SIGNED:		DATE SIGNED:		DATE SIGNED: REASON FOR DISAPPROVAL:		
REASON FOR DISAPPE	ROVAL:			REASON FOR DISA	APPROVAL:	
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MEDICAL INSTR	UMENTS				FORM	
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REASON:							
ENDORSED BY:		RECOMMENDED BY:		APPF	APPROVED BY:		
Approved	○ Disapproved	Approved	O Disapprov	ed OA			
Immediate Superior Department Director			KATHLEEN REYES, MHM, DBA				
Immediate Superior (Signature over Printed Name)		(Signature over Printed Name)			Chief Operating Officer		
DATE SIGNED:		DATE SIGNED:			DATE SIGNED:		
REASON FOR DISAPPROVAL:					REASON FOR DISAPPROVAL:		
RMI FORM HPD 011							