REQUEST of EXTRA DUTY PAY
Unified School District No. 417

Claim for reimbursement for extra duty pay. PLEASE COMPLETE CLAIM & SUBMIT TO BUILDING PRINCIPAL. DUE AT DISTRICT OFFICE BY THE 10th OF EACH MONTH.

Name:					
Date MM/DD/YY	**Activity**	**Purpose**	**Start Time**	**End Time**	**Total Time**

Please report hours in decimal form. Use hourly increments of .25, .5, and .75

I certify the above claim is true and correct and the indicated hours are due for payment.

_____
Signature

Approved by:

_____
Building Principal

Approved by:

_____
Superintendent