KRONOS TIME AND ATTENDANCE PROFILE
FAX TO: **216-636-7154**

EMPLOYEE NAME:____ EMP #: ___________

JOB CLASS:_________________ JOB TITLE :____

LAWSON ACCOUNTING UNIT: __________________________

NEW HIRE:____ TRANSFER: ____ CHANGE: _____ EFFECTIVE DATE: ____________________

1. ORG/PAY CYCLE:				
C Hourly: B1(clinic) ____ B2(hospital) ____		**CR01** (Children's Rehab) B1: Hourly ____ Union ____		**CMCA/CHCS** (HomeHealth/Hospice) B1: Hourly ____ Visit: Exempt ____ PRN ____

2. SCHEDULE TYPE	
Scheduled Shift (Set start/stop time) __________	Flexible Schedule (Core group of hours) _________

3. MEAL DEDUCTION			
No Meal _____	½ hour ____	¾ hour ____	1 hour____

4. SHIFT/CHARGE/ONCALL ELIGIBILITY		
Eligible for Shift Differential? Yes No	Eligible for On Call? Yes No If yes please provide rate $_________	Eligible for Charge Pay? Yes No If yes please provide rate $ _____

5. SPECIAL STATUS (Job class must be provided on form)		
Anesthesia Weekender ______	Hospital Dept Float RN ______	PRN RN ______
Clinic Pediatric Weekender ______	Hospital Float Weekender ______	Therapy Weekender ______
Home Care Weekender ______	ICU Unit Differential ______	OTHER :
Hospital Weekender RN ______	PRN CRNA ______	
Hospital Float RN ______	PRN LPN ______	

TIMEKEEPER NAME/EMPLOYEE # ____

MANAGER NAME/EMPLOYEE # ____

AUTHORIZED SIGNATURE ____ 12/07

CONTACT NAME & PHONE ____