U.S. Department of State

TIME AND ATTENDANCE

(Make a selection)

Employee Name *(Last, First, Middle Initial)*	Scheduled Start Time	Scheduled Finish Time

Day	Date	Start Time	End Time	Reg	OT	AL	SL	LWOP	Comp	Total	TW	AWS
Sunday										0.00		
Monday										0.00		
Tuesday										0.00		
Wednesday										0.00		
Thursday										0.00		
Friday										0.00		
Saturday										0.00		
Sunday										0.00		
Monday										0.00		
Tuesday										0.00		
Wednesday										0.00		
Thursday										0.00		
Friday										0.00		
Saturday										0.00		
= Holiday			**TOTALS**	0.00	0.00	0.00	0.00	0.00	0.00			
									GRAND TOTAL	0.00		

Employee's Comments and Certification

☐ By checking this box, I, _____ , certify that I am the individual submitting this document.

Date *(mm-dd-yyyy)*

Supervisor's Comments and Certification

☐ By checking this box, I, _____ , certify that I am the individual submitting this document.

Date *(mm-dd-yyyy)*

DS-4170
11-2024