SHIFT PREMIUM TIME FORM FOR UNIONIZED STAFF

Name: _____
Operation: _____
Manager: _____
Date Submitted to HR: _____

FOR THE WEEK STARTING SUNDAY _____ ____ _____ AND ENDING SATURDAY _____ ____ _____
Month Day Year Month Day Year

Day	**MM/DD/YY**	**Hours Worked during qualifying Shift Premium Period**	**Shift Premium (FINANCE ONLY)**	Mgr Approval	Date Approved
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
		Total Shift Premium Amount:			

Please see article 16.06 in the CBA for hours that qualify for the shift premium

_____
Employee Signature Date

_____
Manager Signature Date

_____
HR Approval Date

***Completed shift premium forms must be submitted to the Manager, HR Administration**