

**TRAVIS COUNTY EMERGENCY SERVICES DISTRICT #1**

**EMPLOYEE OVERTIME / COMP. TIME FORM**

Name: \_\_\_\_\_ Last 4 SSN#: \_\_\_\_\_  
FIRST LAST

Overtime	Comp. Time
Date: ____/____/____ MM DD YYYY	Hours: _____ Rate: _____
Reason: _____	
Approval: _____ SUPERVISOR SIGNATURE	____/____/____ MM DD YYYY

Overtime	Comp. Time
Date: ____/____/____ MM DD YYYY	Hours: _____ Rate: _____
Reason: _____	
Approval: _____ SUPERVISOR SIGNATURE	____/____/____ MM DD YYYY

Overtime	Comp. Time
Date: ____/____/____ MM DD YYYY	Hours: _____ Rate: _____
Reason: _____	
Approval: _____ SUPERVISOR SIGNATURE	____/____/____ MM DD YYYY

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

\_\_\_\_\_  
SUPERVISOR SIGNATURE

\_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY