

☐ Certified

LITTLE ROCK SCHOOL DISTRICT
810 WEST MARKHAM
LITTLE ROCK, ARKANSAS 72201

☐ Classified

Additional Compensation Form

SITE _____

PAY PERIOD _____

Name

Employee ID #

School/Department

Address

City

Zip

DATE OF WORK	TITLE/DESCRIPTION OF WORK PERFORMED	START TIME	END TIME	TOTAL HOURS	TOTAL PAY

NOTE: Please make all entries in hours. Maximum number of hours per day: 8 TOTAL _____

Employee Signature

Date

Program Manager & Principal

Date

Coordinator

Date

Supervisor/Approver Signature

Date

Federal Time Certification – SATURDAY PROGRAMMING: My signature along with the supervisor's signature **certify that 100% of my participation** relative to this activity is in compliance with **ESSER II FUNDING** ☐. The information recorded on this form is true and correct to the best of my knowledge.

BUDGET CODES MUST BE COMPLETED BY
SCHOOL/DEPARTMENT OR FORM WILL NOT BE PROCESSED.

ACCOUNT CODES

FUND	FUNCTION	OPER UNIT	PROGRAM	PROJECT	SUBJECT	OBJECT