Carolina Family Health Centers, Inc.

Employee Time Certification

EMPLOYEE NAME (PRINT): _____

TIME PERIOD: _____ TO: _____

Column C in the table below lists the percent of time charged to each program of Carolina Family Health Centers, Inc. for the above-named employee and time period. If the percent amounts are correct, sign below. If percent amounts are not correct, make changes in column D, then sign below.

A	B	C	D
PROGRAM NAME	ACCOUNTING CODE	PERCENT CHARGED (MUST TOTAL 100%)	PERCENT CORRECTION (MUST TOTAL 100%)
Fed HRSA CHC/MHC/QI	121		
Fed Ryan White Part C	200		
NC Ryan White Part B	300		
NC Ryan White HOPWA	305		
NC ORH Medication Assistance	310		
NC ORH	350		
NC BCCCP	370		
HRSA PPP	226		
H8D	219		
H8C	222		
H8F	232		
H7C-RW Part C EIS COVID	200		
IBHS	510		
Non-Grant Revenue	999		
TOTAL			

I certify that for the time period listed above, I worked my compensated hours as listed in Column C or corrected in Column D.

_____ _____

Employee Signature *Date*

_____ _____

Supervisor Signature *Date*