St. Clair County Community Mental Health Authority
3111 Electric Avenue
Port Huron, MI 48060
Tel: (810) 985-8900 ☎ Fax: (810) 985-7620

M E M O R A N D U M

TO:_____

FROM: Debra B. Johnson

DATE: _____

SUBJECT: ADP Timecard

Your staff Attendance Record covering the pay period beginning _____has the following concerns:

- ☐ Insufficient hours for full time person
- ☐ Use of time not yet accrued from ( ) sick ( ) overtime ( ) vacation ( ) personal
- ☐ Overtime hours incorrect ( ) calculated wrong ( ) flex schedule
- ☐ Overpaid
- ☐ Disability hours incorrect
- ☐ Inaccuracies due to holiday
- ☐ Hours calculated incorrectly
- ☐ Timesheet needs signature
- ☐ Your supervisor approved the attached corrections
- ☐ Other:_____

Follow up action required:

- ☐ Payback plan/adjustment (for all benefits earned)
- ☐ Paid less than full time so owe premium costs = $_____ (To be deducted from paycheck)
- ☐ Progressive discipline: ( ) recommend ( ) required
- ☐ Other:_____
- ☐ Payback Waived Approved Signature:_____

Please review this information carefully and if you have any questions call _____ at 985-8900.

cc: Director (if appropriate)
Supervisor (if appropriate)
Payroll Department
Personnel File