Payment of UIL Camp Staff

Name of Camp: _____

Dates of Camp: _____

Time(s) of Camp Session(s): _____

Transfer of Expense Amount: _____
(Total payroll expense, including additional 3.98%- Medicaid/medicare/TRS/workers comp)

1. **Name:** _____ **Hours worked** _____
   Address:_____ **Rate per hour** _____
   City, State, Zip:_____ **Total (hrs x rate)=**_____
   District Employee: **yes**_____ **No**_____

2. **Name:** _____ **Hours worked** _____
   Address:_____ **Rate per hour** _____
   City, State, Zip:_____ **Total (hrs x rate)=**_____
   District Employee: **yes**_____ **No**_____

3. **Name:** _____ **Hours worked** _____
   Address:_____ **Rate per hour** _____
   City, State, Zip:_____ **Total (hrs x rate)=**_____
   District Employee: **yes**_____ **No**_____

4. **Name:** _____ **Hours worked** _____
   Address:_____ **Rate per hour** _____
   City, State, Zip:_____ **Total (hrs x rate)=**_____
   District Employee: **yes**_____ **No**_____

*duplicate multiple sheets if necessary