

**LSU HCSD Sponsored Projects  
Time and Effort Log  
Bi-Weekly Payroll**

Name (last name first)	Social Security Number	Department Name

Medical Center Name	Project/Program Name	Total Hours Expended this Pay Period

Date:							
Leave Taken							
Total Daily Hrs.							

Date:									Total Hrs. P.P.
Leave Taken									
Total Daily Hrs.									

I certify that to the best of my knowledge, this information is true and correct as it relates to this project.

\_\_\_\_\_  
Signature (Employee) Date

\_\_\_\_\_  
Approved - Supervisor Signature Date

\_\_\_\_\_  
Approved – Project Director Signature Date

**For Completion by Medical Center Financial Staff ONLY:**

Account									
Fund Code									
Dept ID									
Program	95001								
Class		61010							
Project ID									
Budget Period									FY 2004
Total Hours									

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date