LOUISIANA DEPARTMENT OF HEALTH
PRIOR PAY PERIOD ADJUSTMENT FORM

PAY PERIOD NUMBER TO ADJUST		PAY PERIOD DATES		PERS AREA NUMBER		OFFICE/SECTION	

EMPLOYEE NAME		**HR ADMINISTRATION ENTRY ONLY**									
EMPLOYEE PERSONNEL NUMBER		DATE									
TIME ADMINISTRATOR NAME		HR ADMINISTRATION SIGNATURE									
TIME ADMINISTRATOR NUMBER		ACTION TAKEN:	Time File		Adjustment		JV				
TIME ADMINISTRATOR TELEPHONE NO. & EXT.		Reversal		Off Cycle		Correction		On Demand			
DATE		Current Pay Period Correction Entered									

ORIGINAL DATA ENTERED

CORRECT DATA TO BE ENTERED

DATE		HRS	TYPE	COST CENTER	FUND	INTERNAL ORDER	WBS ELEMENT	FUNCTIONAL AREA	GRANT	HRS	TYPE	COST CENTER	FUND	INTERNAL ORDER	WBS ELEMENT	FUNCTIONAL AREA	GRANT
1																	
2																	
3																	
4																	
5																	
6																	
7																	
8																	
9																	
10																	

COMMENTS:_____

I HEREBY CERTIFY THAT THE ABOVE ADJUSTMENT IS ACCURATE AND SUPPORTED BY APPROPRIATE DOCUMENTATION:

APPROVED BY: TITLE: DATE: