



CITY OF GALLUP

Overtime Time Request Form

Date: _____

Employee Name: _____ Department: _____

Estimated Time: _____ HRS.

Date(s) of Overtime: _____ And _____

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Reason for Overtime: _____

Approved or Disapproved _____

Department Head

Actual:

Date: _____

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Total Work Time: _____ HRS. _____ MIN

Date: _____

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Total Work Time: _____ HRS. _____ MIN

Date: _____

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Start Time: _____ AM/PM Ending Time: _____ AM/PM

Total Work Time: _____ HRS. _____ MIN

Employee Signature: _____ Date: _____

PLEASE NOTE: PRIOR APPROVAL IS REQUIRED FOR NON EMERGENCIES