ST. DOMINIC CATHOLIC HOSPITAL, AKWATIA

MONTHLY UNIT/WARD VALIDATION OF STAFF AT POST

This form should be submitted to the **Head of HR BY 15th of every month.**

NAME OF UNIT/WARD: …….. **MONTH:** …….. **YEAR:** ……..

NUMBER OF STAFF AT THE UNIT:……

S/N	NAME	RANK	STAFF ID	NUMBER OF WORKING DAYS		REMARKS
				EXPECTED	ACTUAL	
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

NAME OF HEAD/DEPUTY: …… **RANK:** ……

SIGNATURE: …… **DATE:** ……