TEAM MEMBER COMPENSATION CALCULATOR

Please fill out the information below and fax to 952-432-8460. Please copy as needed.

Doctor/Practice: ____

Employee: ___________________________ **Position:**______________________________

Hourly Rate:___________________ **Date:** _____________________

1. Total hours for which employee was paid: _________ Hours per year paid (include overtime hours)

2. Holiday hours for which the employee was paid: _________Holiday hours per year pd

3. Vacation hours for which the employee was paid: _________Vacation hrs per year pd

4. Sick leave hours for which the employee was paid: _________Sick leave hrs per year pd

5. Miscellaneous hours for which the employee was paid: _________Misc. hrs per year pd

5a. Number of overtime hours for which employee was paid _________Actual overtime hours per year

6. Benefits in addition to base salary:

Commission Earned _________

Social Security _________

State Unemployment Insurance (if applicable) _________

Uniform Allowance _________

Health Club Membership _________

Worker's Comp Insurance _________

State Disability Insurance (if applicable) _________

Medical Insurance _________

Employee: ____

6. Dental Insurance __________

Medical/Dental Care __________

Medical/Dental Reimbursement __________

Benefits in addition to base salary (continued):

Life Insurance __________

Pension Plan Allowance __________

Profit Sharing Allowance __________

Keogh Allowance __________

Retirement Plan Gains (Forfeitures) __________

Continuing Education __________

Child Day Care __________

Employee Gift Award __________

Optical __________

Vacation Condominium, Cabin __________

"Well" Pay __________

Parking __________

Other __________