



REQUEST FOR ADDITIONAL COMPENSATION

Attach this approved form to the PER-3. All sections below must be completed.

Requested for (Name): _____ Empl ID: _____

Above employees current title: _____

Employee's current department: _____ Dept. supporting: _____

Requestor's name: _____

Reason for Request/Need for additional support: _____

Additional Duties to be assumed: _____

Why is it outside of the scope of normal duties: _____

Estimated hours per week required to do these duties: _____

How will the person carry out this duty along with their regular full time job duties? _____

Dates for Additional duties (up to 6 months, cannot cross fiscal years): _____ to _____

Is this a new request or a continuation of prior additional comp? _____

If continuing, dates of prior additional compensation: _____

Consult with compensation if unsure of amount to recommend. Typical additional compensation amounts:

Coordinator level filling in for another coordinator role: \$500 per month

Coordinator level filling in for management level role: \$800 per month

Management level filling in for similar role: \$1,000 per month

Monthly amount requested: _____

Approved: _____
Requestor (Department Supporting) Date

Approved: _____
Current Supervisor (if different from above) Date

Approved: _____
Department Head Date

Approved: _____
Dean Date

Approved: _____
Human Resources - Compensation Date

Approved: _____
Vice Chancellor Administration & Finance Date