



Defined Term Supplemental Pay Request Form

Employee Information

Date Submitted:		Banner ID:	
Employee's ID:		Employee's Position ID:	
Employee's First Name:		Employee's Last Name:	
Employee's Home Department:		Home Department ID:	
Employee's Home College/Unit:		Employee's Hire Date:	
Employee Classification:	Faculty:	10Month	12Month
	Staff:	Full-time	Part-time

Supplement Information

Temporary Assignment	Academic Admin Assignment	Special Chair
Academic Consortium	Course Delivery Incentive	
Please provide a brief description of what is being requested.		
Supervisor's Name:		Supervisor's Job Title:
Effective Start Date:		Effective End Date:
Employee's Job Title:		Proposed Job Title:
Employee's Current Salary:		Proposed Supplement Pay Amount:
Proposed Supplement %:		

Funding

Combo Code:		Please provide any additional information below.			
Account	Fund Code	Department	Program Code	Class Field	Budget Reference
Business Unit	Project	Activity ID	Chartfield1	Operating Unit	Budget ID:

Signatures & Approvals

I have reviewed this request and determined that the increase request meets the internal policies and criteria established to warrant the recommended adjustment. The required signatures below indicate support for this pay exception and confirm that the pay exception will not result in salary equity issues, budget deficiencies, or request for supplemental funds.

Employee's Supervisor:		Date Signed:	
Department Head or Director:		Date Signed:	
Dean or Vice President:		Date Signed:	
HR Representative: (for staff only)		Date Signed:	
Faculty Affairs: (for faculty only)		Date Signed:	
Signature of Provost: (if required)		Date Signed:	
Signature of President: (if required)		Date Signed:	

Justification

This request is submitted with the understanding that the position is mission critical and that all associated funds are available and are not required to meet any budget reductions or program redirections.