ADDED COMPENSATION REQUEST
FOR PROFESSIONAL STAFF ONLY
Fiscal Year 2018-2019

Submit Completed Form to:
Human Resources and Labor Relations

Date of Request ______________________

When properly signed, this form gives official approval for $___________ per hour extended payment covering more than a two-week pay period. No Payment for $____________ per hour for additional services will be made without this form officially approved by the Assistant Superintendent for Human Resources and Labor Relations. This form is not to be used for incidental day-by-day payments.

Name of Staff Member to Receive Payment ____

Building ____

Total Hrs. Requested ______ x Hrly Pay of $_______ = Total Amt. Added Comp. $ __________

Dates of Additional Services ____

Reason for Additional Services ____

____

Account # ____

Employee Signature ____

Signature of Principal/Supervisor ____

Signature of Assistant Superintendent ____

(To Be Completed by Administrative Office)

Approved ______________________________
Name

____
Title

Approved Finance _________________________

Date of Approval _________________________

Approved ______________________________
Superintendent

Date of Approval _________________________

Approved ______________________________
Assistant Superintendent for
Human Resources & Labor Relations

Date ______________________________

Reason (If Denied) _________________________

_________________________Date_______________

APPROVAL IS SUBJECT TO MASTER AGREEMENT PROVISIONS

Rev. 2017